Cumberland County Council

THE HEALTH OF CUMBERLAND 1969

REPORT OF THE COUNTY MEDICAL OFFICER

COUNTY COUNCIL OF CUMBERLAND

ANNUAL REPORT

ON THE

HEALTH OF THE COUNTY

FOR THE YEAR 1969

JOHN LEIPER, M.B.E., T.D., M.B., Ch.B.,
M.R.C.S., L.R.C.P., D.P.H.,
County Medical Officer.

INDEX

PREFACE

To the Chairman and Members of the County Council,

I have the honour to present my annual report for the health of the County of Cumberland for the year 1969.

This is a health audit of a county where something in the region of a quarter of the population have the great benefit of drinking water in which the fluoride content is adjusted to a dental optimum, where there is a well established system of family health teams working in community medicine, where arrangements for the bringing forward of infants and children to group practice centres for vaccination and immunisation against communicable disease is taking place by means of the County Council's computer, where a hospital maternity unit provides agency arrangements for domiciliary confinements that take place in a particular area, and lastly, where the County Medical Officer of Health has set up a small department of Community Health in a District General Hospital in order to ascertain, and evaluate the method of meeting total health needs, and also to help to ensure the functional unification of the health service. This is clearly a county in which community medicine is well advanced and in which the principle of team work between various inter-dependent professional groups of doctors in general and hospital practice, community and hospital nurses and midwives, and social workers, has been in existence for the best part of ten years.

The figures associated with the deaths of infants under one year, and the perinatal death rate continue to be quite satisfactory, and, in addition, for the second consecutive year there have been no maternal deaths. From this happy state of affairs it is quite clear that the obstetric and paediatric teams in hospital, together with their counterparts in community medicine, and, indeed, the increasing education of mothers themselves, must all play major parts.

However, I wonder why a county of such great natural beauty and generally clean air should, in the year, have one hundred and eighteen of its residents dying of cancer of the lung, and one hundred and twentythree from chronic bronchitis? There is no doubt at all in my mind that elimination of cigarette smoking is the greatest single factor needed to prevent these diseases.

Turning to environmental health matters, I understand that traffic experts calculate that between a third and a half of the nation's motorists will be within a day's outing of the Lake District from about August, 1970, onwards. The completion of the new motorway will thus bring a greatly increased number of visitors to a county of such great natural beauty and for some years now my anxiety about adequate sanitary facilities to meet the new situation in the Lake District have been made known to my Health Committee.

This is the eleventh report that I have written to the Cumberland County Council and for some years now I have been emphasising the changes that are occurring in the socio-medical picture. There is no doubt that there is acceleration of the speed of this change, and integration and unification of the national health service seems likely to take place in the near future within an Area Health Authority as indeed will the integration and unification of the social work service inside a new unitary authority of local government. These changes have been foreseen by myself as being both advantageous and inevitable for some years and I am glad to say that all the staff have been kept informed from time to time of the progress of change both locally and nationally. Nevertheless, there is a feeling of unrest and of insecurity amongst all groups of staff at this time of change, and to minimise this it is hoped that the changes that are to come will not be unduly delayed.

Throughout this report runs the idea of functional unification of the health service in this area with its attendant benefits. A great deal of leadership has been shown by all officers of the Health and Welfare Department; my deputy Dr. J. D. Terrell,

and my Senior Administrative Assistant Mr. J. J. Pattinson, have been invaluable in this regard, and great help in the co-ordination of the local arms of the health service has been given both by Mr. R. S. Venters, Chairman, and Mr. W. J. Ball, Clerk to the Special Area Committee; by Dr. H. Nelson, Chairman, and Mr. F. M. Smith, Clerk to the Local Medical Committee, in the period covered by this report.

However, it is to the Chairman of the Health Committee, Mrs. E. G. Cain, O.B.E., J.P., together with her Health and Welfare Committee, that I have looked for support, guidance and help in advising and agreeing the appropriate administrative changes to meet the contemporary socio-medical needs of the community.

This may well be one of the last reports—I anticipate not more than three or four more—that I will be making as County Medical Officer of Health. The new, extended, and accepted role of the Medical Officer of Health as Community Physician is already a reality to me as I continue my work in the community, and in the West Cumberland Hospital, alongside my clinical colleagues whose fine work puts the community so much in their debt.

The report is, thus, one of continued progress, of sensible and often pioneering development, of fine sensitivity to the differing and increasing health needs of this contemporary rural society.

In all this work the advice and professional guidance of the chief officers of the Council, in particular of the Clerk of the County Council, Mr. G. N. C. Swift, and the County Treasurer, Mr. S. Litchfield, has always been made readily available. It has been of inestimable value for me to have been able to rely on such support.

Lastly, I wish to thank all the members of the Health and Welfare Department for their great loyalty and fine service which has made this progress possible.

I have the honour to be Sir,

Your obedient Servant,

John Leiper.

County Medical Officer of Health.

County Health Department,

11 Portland Square,

Carlisle, CA1 1QB.

Telephone — Carlisle 23456

STAFF

County Medical Officer and County Welfare Officer—

J. Leiper M.B.E., T.D., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.

Deputy County Medical Officer and Deputy County Welfare Officer—

J. D. Terrell, M.B., Ch.B., D.P.H., D.C.H.

Area Medical Officers—

C. A. Bentley, B.A., M.R.C.S., L.R.C.P., D.P.H., Northern Area Medical Officer; Medical Officer of Health to the Penrith Urban District Council and the Border, Wigton and Penrith Rural District Councils.

A. Hargreaves, M.B., Ch.B., D.P.H., Western Area Medical Officer; Medical Officer of Health to Workington Borough and Port, Cockermouth Rural District and Cockermouth, Keswick and Maryport Urban Districts.

J. E. O'Malley, M.R.C.S., L.R.C.P., D.P.H., Southern Area Medical Officer; Medical Officer of Health to Whitehaven Borough and to the Ennerdale and Millom Rural District Councils.

Medical Officers in Senior Posts—

J. E. Ainsworth, M.B., Ch.B.

J. E. M. Garland, M.B., Ch.B., D.P.H.

H. M. Marks, M.B., Ch.B.

Medical Officers in Department—

J. R. Hassan, M.B., Ch.B., D.Obst., R.C.O.G. (Also Medical Officer of Health, Alston-with-Garrigill Rural District, and General Practitioner).

K. R. Walker, M.B., Ch.B.

Chief Dental Officer—

R. B. Neal, M.B.E., T.D., L.D.S.R.C.S.

Western Area Dental Officer—

I. R. C. Crabb, L.D.S.R.F.P.S.

Dental Officers—

L. F. Breakey, B.D.S.
J. Colvin, L.D.S.R.F.P.S.
A. B. Gibson, B.D.S.
F. H. Jacobs, L.D.S.
A. R. Peck, L.D.S.
A. M. Scott, L.D.S.
J. W. Stewart, B.D.S.

Welfare Services Officer—

N. Froggatt

Deputy Welfare Services Officer—

I. Duthie, C.S.W., D.P.A.

Social Welfare Officers—
Northern Area

I. H. Moffet, C.S.W., Senior Welfare Officer.
M. Steele.
M. H. Payne.
G. A. H. Miller
Miss J. E. Campling
W. H. Robinson (part-time)

Western Area

Miss E. F. Hall, Senior Welfare Officer.
A. Davidson, R.M.N., S.R.N., C.S.W.
T. Hetherington, C.S.W.
A. Irving.
B. Reeves
Miss L. L. Morris

Southern Area

J. M. Ruddick, C.S.W., Senior Welfare Officer
R. Daley
T. Evans, R.M.N.
Mrs. L. McGeehin, C.S.W.
Mrs. C. Colquitt, Welfare Assistant.

Matrons of Residential Accommodation—

W. L. Anderson, S.R.N., Q.N., Alneburgh House, Maryport.
Mrs. M. Beresford, Grisedale Croft, Alston.
Mrs. M. Campbell, Castle Mount, Egremont.
Mr. E. McKinney, R.M.N., S.R.N., Fairview Hostel, Bransty, Whitehaven.
Miss M. Johnson, Richmond Park, Workington.
Mrs. P. D. Fitz, Lapstone House, Millom.
Miss B. Edgar, Grange Bank, Wigton.
Mrs. M. M. Maclagan, Moot Lodge, Brampton.
Mrs. H. J. Milnes, Derwent Lodge, Papcastle.
Miss A. G. Ross, S.R.N., Parkside, Maryport.
Miss A. D. Wright, Garlieston, Whitehaven
Mrs. R. Wilson, S.R.N., Brackenthwaite, Whitehaven
Miss V. Woodman, S.R.N., The Towers, Skinburness
Mrs. D. J. Crew, S.E.N., Eskdale House, Longtown
Mrs. P. B. Grahamslaw, S.R.N., Inglewood, Wigton.

Home Teachers for the Blind—

Miss J. Burgess
Miss L. D. Fraser
Mrs. G. Mossop
Miss M. Shuttleworth.

Training Centre Supervisors—

J. J. Lace, Dip. N.A.M.H., Adult Training Centre, Distington
Mrs. H. Bowie, Junior Training Centre, Whitehaven
Miss G. L. Lister, Dip. N.A.M.H., Dip. T.C.T.M.H., S.E.N., Junior Training Centre, Wigton.

Consultant Psychiatrists (Part-time) seconded from Newcastle Upon Tyne Regional Hospital Board—

T. R. Burgess, M.R.C.S., L.R.C.P., D.P.M.
T. T. Ferguson, L.R.C.P., L.R.C.S., L.R.F.P.S.

Chief Nursing Officer—

Miss K. J. Hayes, S.R.N., S.C.M., H.V.Cert., N.Admin.Cert. (P.H.)

Deputy Chief Nursing Officer—

Miss J. Byatt, S.R.N., S.C.M., M.T.D., Q.N., H.V.

Area Nursing Officers—

Miss J. M. Crossfield, S.R.N., Q.N., H.V., Cert., N.Admin. Cert. (P.H.)., Western Area.
Miss J. Reid, S.R.N., S.C.M., Q.N., H.V. Cert., Southern Area
Mrs. J. M. Roberts, S.R.N., S.C.M., H.V. Cert., Q.N., Northern Area.

Chiropodists—

G. H. Thomas, M.Ch.S., S.R.Ch.
W. W. Gordon, M.Ch.S., S.R.Ch., S.R.N.
Mrs. D. E. Smart, M.I.C.Ch., S.R.Ch.
Mrs. G. Garrett, M.Ch.S., S.R.Ch.
Mrs. J. Glaister, M.Ch.S., S.R.Ch.
Mrs. J. Austin, M.Ch.S., S.R.Ch.

Orthoptists—

Miss J. A. M. Davies, D.B.O.
Mrs. J. Scott, D.B.O. (Part-time)

Physiotherapists—

Mrs. P. P. Bratt, M.C.S.P. (Part-time)
Miss M. Sivewright, M.C.S.P. (Part-time)

Screening Assistants—

Mrs. J. Laidlaw
Miss A. Jackson
Miss D. Kidd

Speech Therapists—

Mrs. E. M. Blacklock, L.C.S.T.
Miss E. B. Moon, L.C.S.T. (Part-time)
Mrs. S. Latimer, L.C.S.T. (Part-time)
Mrs. J. Stone, L.C.S.T. (Part-time)
Miss S. Caunce, L.C.S.T.
Mrs. M. E. Ogram, L.C.S.T. (Part-time).

County Ambulance Officer—

M. F. Smith, F.I.A.O.

Senior Administrative Assistant—

J. J. Pattinson, D.F.C.

NORTHERN AREA
FAMILY HEALTH CARE TEAMS
DECEMBER, 1969

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. J. R. Hassan Dr. M. I. Khan-Bangash, Alston	Mrs. E. M. Walton Mrs. P. White (Relief) Mrs. A. Davidson (Aux.)	Mrs. E. M. Walton	Miss E. A. Lockhart
Dr. A. K. Rankin Dr. A. M. Rankin Aspatria.	Miss S. West Mrs. J. Dickinson (Relief)	Miss S. West	Miss C. M. Bannan
Dr. A. C. Beeby Aspatria	Mrs. J. Eelbeck (Relief)	Miss G. Jobson (Relief)	Mrs. A. E. Henderson (Relief)
Dr. J. R. Rose Aspatria			
Dr. H. P. Nelson Dr. W. J. Lush Dr. R. E. D. Nelson Dr. J. C. Burn Dr. I. J. Clark Brampton	Miss B. M. Wesson Mrs. F. Gaskin Mrs. K. M. Bell (Relief) Mrs. T. Wight (Relief) Mrs. P. Alexander (Aux.)	Mrs. F. M. Hurst Miss V. Dodgson (Relief)	Miss B. Knibbs Miss E. Tongue Mrs. A. Gallacher
Dr. M. I. Cox Dr. A. G. MacKenzie Caldbeck	Miss E. Henderson Mrs. E. Howat (Relief)	Miss E. Henderson Mrs. M. Thom (Relief)	Miss E. Henderson Miss P. B. Simpson (Relief)
Dr. W. P. Hayne Dr. H. J. Bradley Dalston	Mrs. M. E. Wilde Mrs. M. Thom (Relief) Mrs. M. Faulder (Relief)	Mrs. M. E. Wilde Mrs. M. Thom (Relief)	Miss P. B. Simpson Miss E. Henderson (Relief)
Dr. N. W. Cameron Hesket	Miss J. R. N. Byres Mrs. G. Dye (Relief)	Miss J. R. N. Byres Mrs. M. Dobson (Relief)	Mrs. D. Edmondson Mrs. M. McCredie (Relief)
Dr. N. C. F. Milne Kirkoswald	Miss J. R. N. Byres Mrs. G. Dye (Relief)	Miss J. R. N. Byres Mrs. M. Dobson (Relief)	Mrs. M. McCredie Mrs. D. Edmondson (Relief)

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. D. A. McDonald Dr. R. A. Maxwell Kirkbride	Miss A. A. Cockton Mrs. M. Bendle (Relief)	Miss A. A. Cockton Mrs. D. Lancaster (Relief)	Mrs. D. Lancaster
Dr. R. A. Forrester Longtown	Miss V. Dodgson Mrs. B. Buchanan	Miss V. Dodgson	
Dr. G. M. Ingall Longtown	Mrs. F. M. Hurst (Relief) Mrs. H. Harper (Relief)	Mrs. F. M. Hurst (Relief)	Miss M. Butler
Dr. H. C. Barr Dr. I. M. Johnstone Dr. G. F. Lewis Dr. R. W. Corner Penrith	Mrs. E. J. Relph Mrs. M. Judson Mrs. A. Metcalfe (Relief)		Miss K. Rigby Miss A. M. Murray
Dr. G. H. Kilgour Dr. C. H. Thomson Penrith	Mrs. V. M. Lamb Mrs. M. J. Woodhall	Mrs. V. M. Lamb Mrs. S. A. Barnes	Miss D. Roulstone
Dr. K. Todd Dr. J. B. Scott Dr. I. O. Miller Penrith	Mrs. S. A. Barnes Mrs. E. Plant Mrs. M. M. Barnard (Relief) Mrs. G. Woodhall (Aux.)		Miss I. Arnott
Dr. H. Hutton Dr. R. M. Yule Silloth	Miss G. Jobson Mrs. N. Reay (Relief)	Miss G. Jobson Mrs. A. E. Henderson (Relief)	Mrs. A. E. Henderson Miss C. M. Bannan (Relief)
Dr. W. Hetherington Dr. D. A. Nisbet Wetheral	Miss M. Weightman Mrs. F. Yeomans (Relief)	Mrs. M. Dobson Miss J. R. N. Byres (Relief)	Miss E. A. Lockhart Mrs. M. Dobson (Relief)
Dr. T. M. Dolan Dr. G. A. H. Jones Dr. N. Gray Wigton	Mrs. D. Lancaster Mrs. M. Hope Mrs. M. Jones (Relief)	Mrs. D. Lancaster Miss A. A. Cockton (Relief)	Mrs. M. Hedworth

General Practitioners	Home Nurses	Midwive	Health Visitors
General Practitioners practising outside the Administrative County.			
Dr. K. Gillow Dr. T. Mooney Dr. T. Gardner Dr. G. Raitt Dr. J. F. McKellican Dr. A. Backman Carlisle	Mrs. E. M. Stafford (Surgery Nurse)		Mrs. M. Dobson
Dr. G. Jolly Dr. W. C. Menzies Dr. W. P. Honeyman Dr. N. C. Frame Carlisle.	Mrs. J. Branthwaite Mrs. F. Yeomans (Relief	Mrs. M. Dobson	Miss E. A. Lockhart
Dr. D. W. Barnes Dr. P. K. Wheatley Carlisle	Mrs. M. Dobson		Mrs. M. Dobson
Dr. E. M. Simpson Dr. I. L. Roy Dr. B. Spencer Dr. W. G. H. Allan Carlisle	Miss A. A. Cockton Mrs. M. Bendle (Relief)	Miss A. A. Cockton	Miss A. A. Cockton
Dr. D. M. C. Ainscow Temple Sowerby	Mrs. V. M. Lamb		
Dr. P. Delap Appleby	Mrs. M. J. Woodhall	Mrs. V. M. Lamb	Miss D. Roulstone
Dr. J. D. Ogilvie Glenridding,	Mrs. M. J. Mathews Mrs. D. Scoon (Relief)	Mrs. M. J. Mathews	Mrs. M. J. Mathews

SOUTHERN AREA

FAMILY HEALTH CARE TEAMS

DECEMBER, 1969

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. H. Calder Dr. J. Sharp Distington	Miss J. A. G. Hardie Mrs. M. C. Donnan Mrs. S. Hunter (Relief)	Miss J. A. G. Hardie	Miss J. A. G. Hardie
Dr. W. R. Hunter Dr. J. Veitch Dr. D. Earnshaw Egremont & Cleator Moor	Mrs. V. Wrightson Mrs. M. T. Toole Mr.s A. Rea (Relief)	Mrs. V. Wrightson Miss E. M. Miller	Miss M. E. Gibson Miss R. Sheppard
Dr. E. Braithwaite Dr. J. W. Strain Egremont & Cleator Moor	Mrs. A. Gell Mrs. D. Adair (Relief)	Mrs. V. Wrightson	Mrs. A. Donald
Dr. A. S. Smith Dr. L. Henry Egremont and Cleator Moor	Mrs. F. Corkhill Mrs. M. Weightman (Relief)		
Dr. W. G. McKay Dr. C. Donald Dr. H. E. Johnston Cleator Moor & Frizington	Miss H. Spencer Mrs. J. Niles (Relief)	Miss M. Proctor	Miss P. Walsh
Dr. A. E. Jackson Dr. M. J. Leverton Dr. A. J. Todd Dr. I. C. Mathieson Millom	Miss I. A. Wilson Mrs. I. Booth Mrs. M. K. Wilson Mrs. S. E. Troll Mrs. B. Bawden (Surgery Nurse) Mrs. M. J. Fazackerley (Relief, Mrs. M. Paterson (Aux.)	Miss Wilson Mrs. I. Booth	Mrs. I. E. Bowe

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. J. Loudon Dr. J. W. Jago Dr. J. M. Kirk Dr. A. M. Smith Seascale	Miss D. D. James Mrs. M. Marshall Mrs. E. Brannon Mrs. E. Gallantry (Surgery Nurse) Mrs. A. M. Brightman (Relief) Mrs. P. Heggie (Relief) Mrs. J. A. Capp	Miss D. D. James Mrs. M. Marshall	Miss D. D. James Mrs. M. Marshall
Dr. M. C. Nicolson Dr. R. N. Galloway Dr. P. T. Higgins Dr. R. H. Pearson Whitehaven	Mrs. I. Routledge Mrs. H. Egan Mrs. A. Keenan (Surgery Nurse) Mrs. B. Tinnion (Relief)		Mrs. S. Crellin Mrs. W. Batey
Dr. R. W. Chalmers Dr. A. P. Timney Whitehaven	Mrs. M. West Mrs. A. D. Graham (Relief)		Miss I. M. Alcock
Dr. J. Gilmour Dr. B. Moss Whitehaven	Mrs. M. Swinburne Mrs. I. Smith (Relief)	Mrs. M. Ainsworth	Miss I. M. Alcock
Dr. H. A. Fleming Dr. J. G. Dickson Dr. E. Graham Whitehaven	Miss J. Woodend Mrs. M. J. Vincent (Relief)		Miss A. Singleton
Dr. R. C. McFarlane Whitehaven	Mrs. E. Brannon Mrs. D. J. Cameron (Relief)		Mrs. A. Petch

WESTERN AREA

FAMILY HEALTH CARE TEAMS
DECEMBER, 1969

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. T. Fletcher Dr. E. B. Herd Dr. M. G. Porteous Cockermouth	Miss A. I. Kirk) Miss M. Musgrave) Mrs. V. Sherwood) Mrs. E. Swindle (Relief)) Mrs. J. Thomas (Relief))	Miss A. Kirk Miss M. Musgrave	Mrs. M. Lythgoe Miss A. Dixon
Dr. A. G. Abraham Cockermouth	Mrs. K. Lytollis) Mrs. M. E. Dobson (Relief))		Miss M. Reynolds
Dr. R. J. M. Irvine Cockermouth	Mrs. M. E. Dobson) Mrs. K. Lytollis (Relief))		Miss M. Reynolds
Dr. J. A. Harrow Keswick	Miss S. M. J. Iliffe	Miss S. M. J. Iliffe	Mrs. A. E. Campbell
Dr. J. D. Mitchell Keswick	Miss M. Casey Mrs. M. J. Cox (Relief)	Miss H. Rae	Miss M. Casey
Dr. T. Donaldson Keswick	Miss H. Rae	Miss H. Rae	Mrs. A. E. Campbell
Dr. I. F. Smith Keswick	Miss S. M. J. Iliffe Mrs. J. E. Barnes (Relief)	Miss S. M. J. Iliffe	Mrs. A. E. Campbell
Dr. J. D. H. Bird Dr. S. A. W. Rattrie Dr. K. Longstaff Dr. B. J. Havard Dr. F. W. Clark Dr. C. M. Yule Maryport	Miss A. Chadwick Miss O. Pickering Miss J. Gate Mrs. A. Irving Mrs. M. Robinson Miss G. Whalley (Relief)	Miss O. Pickering Miss A. Chadwick Miss J. Gate	Miss S. Twigg Mrs. L. Williams

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. R. E. Fletcher Dr. R. H. Fletcher Dr. W. H. Fletcher Dr. A. Craig Workington	Mrs. J. Palin Mrs. L. Daniels (Relief)		Miss A. Jackson
Dr. D. N. Fitzgerald Workington	Mrs. M. I. Lowis Mrs. J. E. Brown (Relief)		Mrs. M. Hewitson
Dr. N. McKerrow Dr. P. I. Rutherford Dr. M. O. Sime Workington	Miss M. Young Mrs. D. Fisher Mrs. M. K. Tunstall		Miss E. J. Surtees Mrs. J. A. Graham
Dr. J. Pavey-Smith Dr. I. R. McLeod Workington	Mrs. M. Hamilton Mrs. L. Messenger Mrs. P. Cross (Relief)	* Mrs. M. K. Tunstall Miss J. Cunliffe	Mrs. H. Watson
Dr. C. Robinson Dr. Price Dr. R. F. Longdin Workington	Mrs. J. M. Brown Mrs. J. M. Potts Miss J. Cunliffe	(Ante and Post Natal Care)	Miss G. Davies
Dr. G. M. Thomas Workington	Mrs. M. I. Lowis Mrs. J. E. Brown (Relief)		Mrs. D. R. Bari
Dr. R. N. R. Grant Workington	Mrs. M. I. Lowis Mrs. J. E. Brown (Relief)		Mrs. D. R. Bari
	Mr. T. D. M. Holmes. Male Nurse Mr. T. G. Cartner. Male Nurse Mrs. M B. White	Work with all Workington Practices	

* Confinements covered by Workington Infirmary Hospital Staff.

ADMINISTRATION

The day-by-day administration of almost all aspects of the health and welfare services (the only significant exceptions being the ambulance and dental services) is delegated to the three Area Medical Officers. Each is responsible for the smooth running of the services for a population of about 75,000, although their areas differ significantly in geographical size. The northern area, which is the most rural in character, is, at 612,000 acres, much larger than the other two combined.

The Area Medical Officers are responsible to Area Health Sub-Committees which have a wide representation and include among their members hospital consultants, general practitioners, teachers and representatives of district councils. For the management of the residential Homes each of these Area Committees has a House Sub-Committee.

The Area Sub-Committees report to the Health, Housing and Welfare Committee each quarter, as do the Joint Health and Education Sub-Committee (which deals with matters pertaining to the school health service and health education in general), the General Purposes Sub-Committee (which deals with matters of policy and finance and the affairs of the ambulance service), and the Joint Committee established to administer the Workshops for the Blind on behalf of the Cumberland and Westmorland County Councils and Carlisle Borough Council.

The County Council has been considering the simplification of its administration and one of the proposals is to make a significant reduction in the number of Committees. To this end the House Sub-Committees, the General Purposes Sub-Committee and the Joint Health and Education Sub-Committee will cease to exist after the County Council elections in 1970. At the same time there will be more delegation of responsibility to the County Medical Officer and the Area Medical Officers, leaving the Committees free to concentrate on matters of policy and duties placed on them by statute.

The administration of the health and welfare services in this county is undoubtedly smoothed by the ready co-operation of the

other branches of the health service, especially by way of the various committees and groups on which we have cross representation.

A Health and Medical Services Liaison Group meets twice a year to discuss the effects of policy decisions and actions by one branch of the service on the others. The Group is mostly professional, with representation from this authority, the Carlisle authority, the Special Area Committee of the Regional Hospital Board, the Cumberland and Carlisle Executive Councils and the Cumberland and Carlisle Local Medical Committees.

There are active Local Maternity Liaison Committees in each of the two hospital management areas and I, or my deputy, are able to attend meetings of the West Cumberland Hospital Management Committee, Garlands Medical Advisory Committee and the Cumberland Local Medical Committee. I attend meetings of the Special Area Committee of the Regional Hospital Board and the Chief Nursing Officer is a member of the East Cumberland Hospital Management Committee.

All these contacts are invaluable in helping to overcome the separation of the services which present legislation imposes, although I believe that the biggest contribution in this direction in 1969 was the opening of the Department of Community Health and Epidemiology in West Cumberland Hospital. This, and my work there as Community Physician are reported fully elsewhere in this Report.

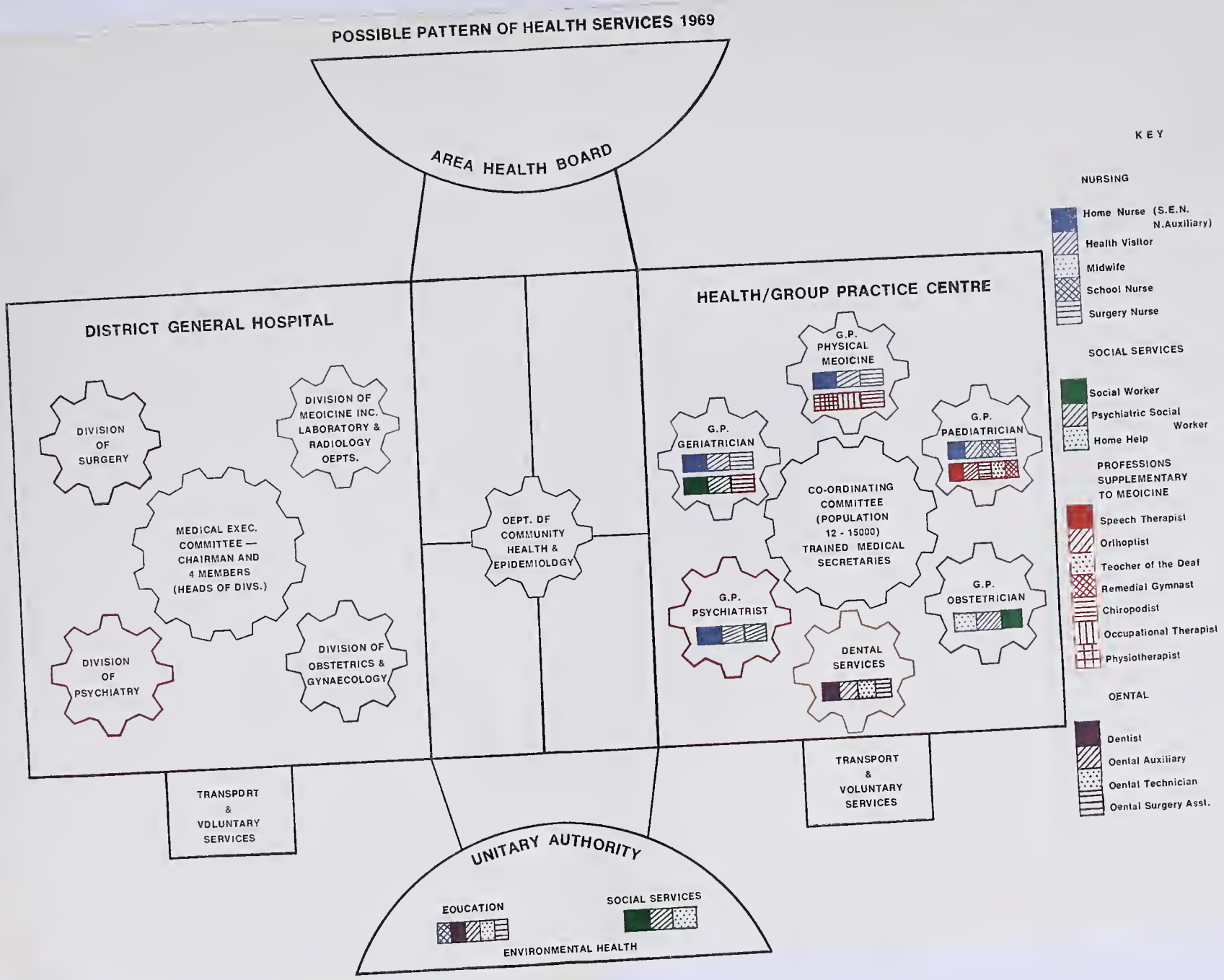
I am pleased to report that, after protracted negotiation with some of the county district councils, the new scheme for the appointment of area medical officers, who would also act as medical officers of health to all county district councils in their areas, was brought into operation on 1st November, 1969. The scheme also provides for the deputy area medical officers sharing in the work of district medical officers of health for one-third of their time. Unfortunately, all three posts of deputy have been vacant since the inception of the scheme and, while one appointment has been made, the response to advertisements for the other two has been extremely poor. The filling of these posts is obviously going to

be one of the difficult problems of the immediate future and throws a considerable burden on the area medical officers in fulfilling their district functions. While the district councils may, on the whole, be getting rather less service than had been hoped, this must be weighed against the fact that many of them would have been completely without the services of a medical officer of health if the re-organisation had not been put into effect.

Except for medical staff, the recruitment position is satisfactory. After several years of difficulty the dental staff was, at the end of the year, up to full establishment. The scholarship schemes for the training of speech therapists and orthoptists are now paying dividends and it is expected that similar results will shortly come from the dental auxiliary, physiotherapy, occupational therapy scholarships which were instituted by the authority in 1969. Those for the training of physiotherapists and occupational therapists are provided jointly with the West Cumberland Hospital Management Committee, probably a unique arrangement I believe, and the scholarship holders will, on completion of their training, be employed on both local authorty and hospital work. Experience so far suggests that the scholarship scheme is the answer to many staffing problems.

Returning to the matter of the functional integration of the health service at medical level, I have for some time been considering how the re-organisation of medical work in hospitals and in general practice would phase in together, and the role which the community physician might be able helpfully to play in this.

In hospitals variations on the recommendations of the Godber ("Cogwheel") Report have emerged in most hospital groups: and in general practice the move towards larger group practices in improved premises to accommodate the family health care team, has developed. I show (below) diagramatically a possible pattern of health services taking account of these changes, all occurring alongside the local government re-organisation and the emergence of Area Health Authorities.


POSSIBLE PATTERN OF HEALTH SERVICES 1969
AREA HEALTH BOARD
DISTRICT GENERAL HOSPITAL
DIVISION OF SURGERY
DIVISION OF MEOICINE INC. LABORATORY & RADIOLOGY OEPTS.
MEDICAL EXEC. COMMITTEE — CHAIRMAN AND 4 MEMBERS (HEADS OF DIVS.)
DIVISION OF PSYCHIATRY
DIVISION OF OBSTETRICS & GYNAECOLOGY
OEPT. OF COMMUNITY HEALTH & EPIDEMIOLOGY
HEALTH/GROUP PRACTICE CENTRE
G.P. PHYSICAL MEOICINE
G.P. GERIATRICIAN
G.P. PAEDIATRICIAN
CO-ORDINATING COMMITTEE (POPULATION 12 - 15000) TRAINED MEDICAL SECRETARIES
G.P. PSYCHIATRIST
G.P. OBSTETRICIAN
DENTAL SERVICES
TRANSPORT & VOLUNTARY SERVICES
TRANSPORT & VOLUNTARY SERVICES
UNITARY AUTHORITY
EDUCATION
SOCIAL SERVICES
ENVIRONMENTAL HEALTH
KEY
NURSING
Home Nurse (S.E.N. N.Auxiliary)
Health Visitor
Midwife
School Nurse
Surgery Nurse
SOCIAL SERVICES
Social Worker
Psychiatric Social Worker
Home Help
PROFESSIONS SUPPLEMENTARY TO MEOICINE
Speech Therapist
Orthoptist
Teocher of the Deaf
Remedial Gymnast
Chiropodist
Occupational Therapist
Physiotherapist
OENTAL
Dentist
Oental Auxiliary
Oental Technician
Oental Surgery Asst.

Area	Area Medical Officer	Districts covered	Total Acreage	Total population	Births in 1969	Child Health		Training Centres		Part III Accomm.		Sup. Ind. Places
						Centres	Attendances	Centres	Places	Homes	Places	
Northern	Dr. C. A. Bentley, 13 Portland Square, Carlisle, CA1 1PZ	Alston R.D. Border R.D. Penrith R.D. Penrith U.D. Wigton R.D.	612,000	76,920	1,162	14	9,155	1	45	8	190	150
Western	Dr. A. Hargreaves, Stoneleigh, Park End Road, Workington.	Cockermouth R.D. Cockermouth U.D. Keswick U.D. Maryport U.D. Workington M.B.	173,000	73,780	1,069	8	8,854	1	80	3	94	112
Southern	Dr. J. E. O'Malley, Flatt Walks, Whitehaven.	Ennerdale R.D. Millom R.D. Whitehaven M.B.	182,000	73,740	1,170	8	13,009	1	75	4	135	36

GENERAL STATISTICS AND SOCIAL CONDITIONS OF THE AREA

The apparent levelling off in the outward migration from the county as indicated by the Registrar General's adjustments of population in 1968, has not been maintained and the mid-year estimate for 1969 allocates 1,260 persons less to Cumberland this year. Taking into account the natural increase of 644 this represents a total outward migration of 1,904 persons. This is in itself a great loss to the county representing almost 1% of the total population and brings the total outward migration since 1964 to 6,106 almost 3%.

A breakdown of the loss reveals that the population of Millom Rural District has decreased by 150; of Whitehaven Municipal Borough by 200; of Workington by 280; of Maryport Urban District by 110; and of Border Rural District by 620. These can be related to the changes in the social conditions in the areas concerned; namely the closure of the Millom Ironworks, the uncertain future of the United Steel Company's plant at Workington and the closure of the Hadrian's Army Apprentice Training Camp.

Industrial development in West Cumberland, plus promised improvements in the road system, namely the A66 trunk road from Penrith to West Cumberland and the Cumberland and Westmorland section of the M6 should, it is hoped, at least help to arrest the flow of migrants in the near future. It is estimated that by 1974 the opening of this section of the M6 will bring 21½ million people within three hours easy motoring distance of the Lake District, and will no doubt increase the number of visitors to this county, bringing with them associated environmental health problems. In this connection the provision of toilet facilities is causing me much concern at the moment.

Vital Statistics

Births

The crude birth rate of the county has remained static at 15.2 births per 1,000 total population, the number of births 3,401 being almost identical to the 3,400 of 1968.

The graph on page 34 shows the comparison of the birth rates for the administrative county and England and Wales and illustrates the continued fall in both rates.

Illegitimate births at 224 represented 6.6% of total births and maintains the favourable position of the county in relation to England and Wales.

The low number of stillbirths at 47 and the rate of 13.6 stillbirths per 1,000 live and stillbirths, although slightly above that for 1968 (12.8), is comparable to the rate of 13.2 for England and Wales.

The perinatal mortality rate—stillbirths and first week deaths —of 24.9 per 1,000 total births, although above the 1968 rate, (23.2) continues to be quite satisfactory.

Notifications of stillbirths and first week deaths are investigated and the results of these investigations discussed at the East and West Cumberland Maternity Liaison Committees which now meet bi-annually. There was a rather sharp increase in the early neo-natal deaths in the East Cumberland Hospital Management Committee area over the last three months of the year. Investigation has shown that most of the eleven cases concerned were due to, or associated with, prematurity and included several multiple births. Seven of the deaths were from the latter group.

Maternal Mortality

Once again, as in 1968, there were no deaths associated with pregnancy.

Death Rate

There was a fall in the number of deaths, 2,757 compared with 2,789 for 1968 and the crude death rate has fallen slightly to 12.3 deaths compared to 12.4 deaths per 1,000 total population (England and Wales provisional rate 11.9).

Deaths from Heart Disease

This year I have been investigating the incidence of deaths from heart disease in the county over the period 1961-67. By using the indirect method of standardised mortality based on the 1961

census of population; it was established that statistically the number of deaths from heart disease was significantly high compared with England and Wales. Additionally, in order to cater for any possible changes in the age/sex structure, it was felt necessary to conduct a similar exercise based on the 1966 sample census of population. This covered the years 1966 and 1967 and confirmed the other result. The results of both exercises can be seen in the following table.

Strict comparison of deaths from heart disease is not possible after 1967, owing to the revision of the Registrar General's Internatonal Classifications in 1968.

The impact of this investigation is that for males, and to a greater extent for females, deaths from heart disease in Cumberland is at a higher rate than in England and Wales. The establishment of such facts is the essential pre-requisite to any epidemiological study of mortality in an area. The actual elucidation of the cause or causes of such mortality data is an exceedingly complex exercise beyond the present resources of the Medical Officer of Health but one which must be faced in the future in the context of the work of the community physician.

Standardised Mortality Ratios for Heart Disease in Cumberland

Year	MALES				FEMALES			
	Actual Number of Deaths	Expected Number of Deaths	Standardised Mortality Ratio	Significant or Not Significant	Actual Number of Deaths	Expected Number of Deaths	Standardised Mortality Ratio	Significant or Not Significant
BASED ON 1961 CENSUS								
1961	470	424	111 to 110.2	Significant	488	353	138 to 112.5	Significant
1962	511	435	117 to 110.4	Significant	368	349	105 to 111.0	Not Significant
1963	556	447	124 to 110.6	Significant	411	351	117 to 111.6	Significant
1964	481	418	115 to 110.5	Significant	399	314	127 to 112.7	Significant
1965	547	430	127 to 110.9	Significant	397	319	125 to 112.5	Significant
1966	526	427	123 to 110.7	Significant	422	316	134 to 113.0	Significant
1967	478	410	117 to 110.7	Significant	419	299	140 to 113.7	Significant
BASED ON 1966 SAMPLE CENSUS								
1966	526	461	114 to 109.9	Significant	422	347	122 to 111.8	Significant
1967	478	442	108 to 109.8	Not Significant	419	330	127 to 112.4	Significant

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

Area in Acres of Administrative County—967,054
Rateable Value (April 1st, 1969)—£7,698,274
Estimated Product of 1d. Rate (1969-70)—£30,649
Population (Census, 1951)—217,540.
Population (Census, 1961)—223,202.
Population/1969 Mid-Year Estimate—224,440.

Live Births — Number	3,401
Rate per 1,000 population	15.2
Illegitimate Live Births per cent of total births	6.6
Still Births — Number	47
Rate per 1,000 total live and still births	13.6
Total Live and Stillbirths	3,448
Infant Deaths (Deaths under 1 year)	64
Infant Mortality Rate—	
Total Infant Deaths per 1,000 total births ...	18.8
Legitimate Infant Deaths per 1,000 total legitimate births	18.3
Illegitimate Infant Deaths per 1,000 total illegitimate births	26.8
Neo-natal mortality rate (Deaths under 4 weeks per 1,000 total live births)	14.1
Early neo-natal mortality rate (Deaths under 1 week per 1,000 total live births)	11.5
Perinatal mortality rate (Still births and Deaths under 1 week combined per 1,000 total live and still births)	24.9
Maternal Mortality (including abortion) — Number of deaths	Nil
Rate per 1,000 total live and still births	Nil

A more detailed analysis of the above figures is given overleaf.

	Male	Female	Total	Urban Districts	Rural Districts	Admin. County	Eng. & Wales
LIVE BIRTHS—							
Legitimate ...	1,635	1,542	3,177				
Illegitimate ...	113	111	224				
	1,748	1,653	3,401				
Birth rate per 1,000 population ...				15.2	15.1	15.2	16.3
STILL BIRTHS—							
Legitimate ...	25	20	45				
Illegitimate ...	1	1	2				
	26	21	47				
Still birth rate per 1,000 total births				11.5	15.1	13.6	13.2
DEATHS—							
All causes ...	1,393	1,364	2,757				
Death rate per 1,000 population ...				12.7	12.0	12.3	11.9
INFANT DEATHS—							
All infants under 1 year of age—							
Legitimate ...	36	22	58				
Illegitimate ...	4	2	6				
	40	24	64				
Total infant deaths per 1,000 total live births				14.6	21.7	18.8	18.1

District	BIRTHS						
	Legitimate	Illegitimate	Total	Births per 1,000 population (crude)	Comparability factor	Stillbirths	Stillbirth Rate
RBAN DISTRICTS—							
Cockermouth	85	2	87	13.6	1.00	1	11.4
Keswick	49	5	54	12.0	1.15	1	18.2
Maryport	156	14	170	14.2	0.96	2	11.6
Penrith	162	17	179	16.0	1.00	1	5.6
Whitehaven	395	31	426	15.9	0.93	4	9.3
Workington	409	49	458	15.4	1.00	7	15.1
Aggregate	1,256	118	1,374	15.2	0.98	16	11.5
RURAL DISTRICTS—							
Alston	26	1	27	13.0	1.25	—	—
Border	396	19	415	13.7	1.12	4	9.5
Cockermouth	280	20	300	14.2	1.02	5	16.4
Ennerdale	527	26	553	17.2	0.99	8	14.3
Millom	180	11	191	12.8	1.08	2	10.4
Penrith	162	6	168	14.7	1.07	1	5.9
Wigton	350	23	373	17.0	1.05	11	28.7
Aggregate	1,921	106	2,027	15.1	1.05	31	15.1
Administrative County	3,177	224	3,401	15.2	1.02	47	13.6

AND POPULATION IN THE YEAR 1969

DEATHS			INFANT MORTALITY										
Total Deaths	Deaths per 1,000 population (crude)	Comparability factor	Total Infant Deaths	Legitimate	Illegitimate	Neonatal Deaths	Early Neonatal Deaths	Infant Death Rate	Neonatal Rate	Early Neonatal Rate	Perinatal Deaths	Perinatal Death Rate	Estimated Mid-year population
83	13.0	1.09	—	—	—	—	—	—	—	—	1	11.4	6,410
81	18.0	0.81	4	2	2	3	2	74.1	55.6	37.0	3	54.5	4,500
155	12.9	1.19	3	2	1	2	2	17.7	11.8	11.8	4	23.3	12,000
158	14.2	0.89	2	2	—	2	—	11.2	11.2	—	1	0.6	11,170
317	11.9	1.16	9	8	1	6	4	21.1	14.1	9.4	8	18.6	26,760
358	12.1	1.15	2	1	1	1	1	4.4	2.2	2.2	8	17.2	29,710
1,152	12.7	1.10	20	15	5	14	9	14.6	10.2	6.5	25	18.0	90,550
26	12.6	0.85	—	—	—	—	—	—	—	—	—	—	2,070
427	14.1	0.87	14	14	—	14	13	33.7	33.7	31.3	17	40.6	30,300
238	11.3	1.10	6	5	1	4	2	20.0	13.3	6.7	7	23.0	21,160
337	10.5	1.22	9	9	—	5	5	16.3	9.0	9.0	13	23.2	32,080
154	10.3	1.27	5	5	—	3	2	26.2	15.7	10.5	4	20.7	14,900
114	10.0	1.04	4	4	—	4	4	23.8	23.8	23.8	5	29.6	11,410
309	14.1	0.93	6	6	—	4	4	16.1	10.7	10.7	15	39.1	21,970
1,605	12.0	1.04	44	43	1	34	30	21.7	16.8	14.8	61	296.	133,890
2,757	12.3	1.06	64	58	6	48	39	18.8	14.1	11.5	86	24.9	224,440

MORTALITY TRENDS IN CUMBERLAND

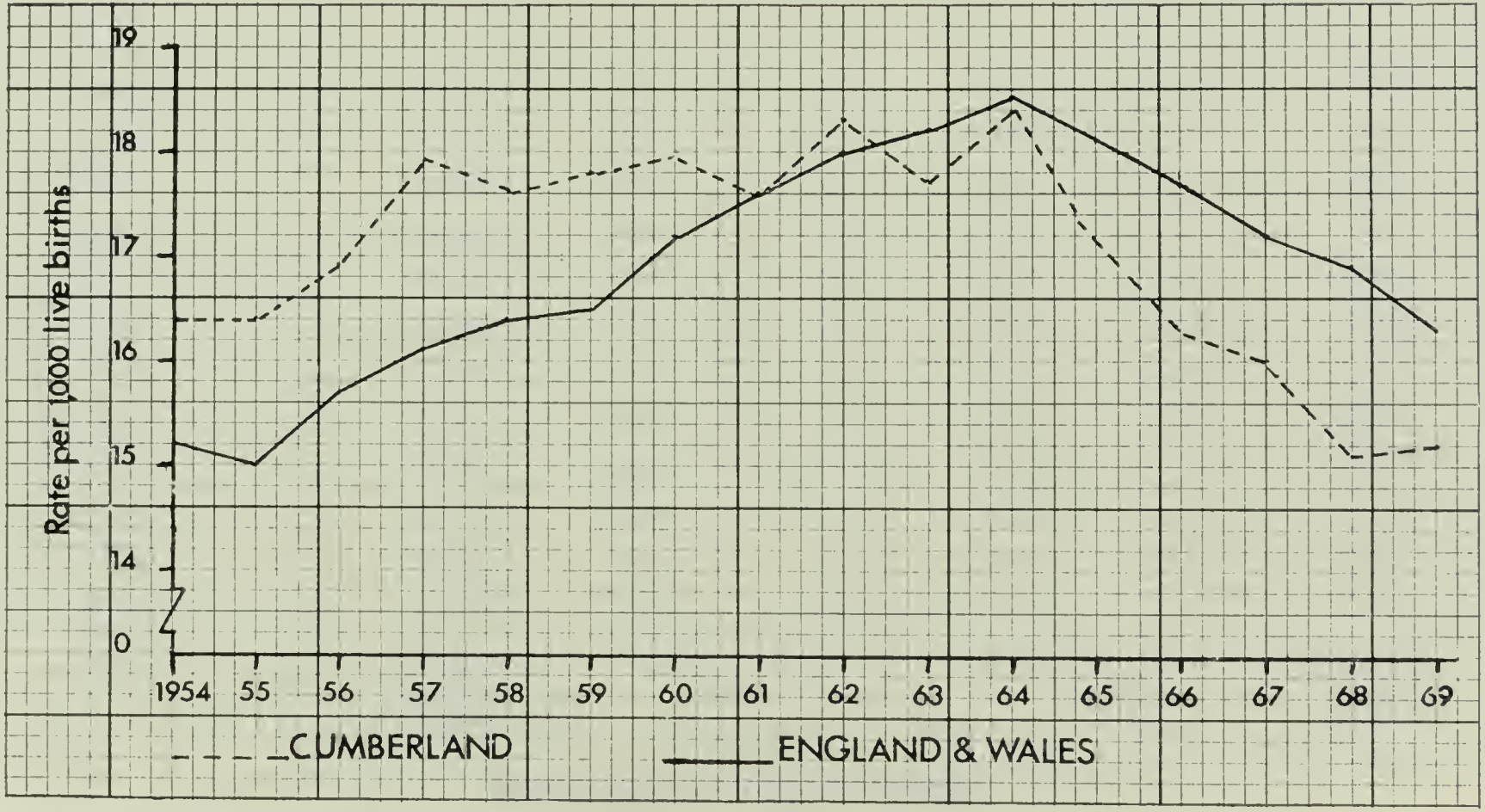
Year		Under 1	1—	5—	15—	25—	45—	65—	75+	Total
1929	...	275	128	67	122	284	638	654	711	2,879
		9.6%	4.4%	2.3%	4.2%	9.9%	22.2%	22.7%	24.7%	Rate 13.3
1939	...	173	37	46	112	211	597	687	805	2,668
										Rate 13.4
1959	...	82	8	16	27	81	575	712	1110	2611
										Rate 11.9
1960	...	91	13	19	21	105	554	677	1149	2629
										Rate 12.0
1961	...	88	7	19	19	86	570	747	1189	2725
										Rate 12.3
1962	...	108	15	13	15	114	574	759	1125	2723
										Rate 12.1
1963	...	87	8	11	33	97	648	721	1208	2813
										Rate 12.5
1964	...	76	19	14	24	88	626	705	1118	2670
										Rate 11.8
1965	...	66	11	13	29	89	618	750	1130	2706
		2.4%	0.4%	0.5%	1.1%	3.3%	22.8%	27.7%	41.8%	Rate 12.0
1966	...	77	6	13	25	96	588	732	1224	2761
		2.8%	0.2%	0.5%	0.9%	3.5%	21.3%	26.5%	44.3%	Rate 12.3
1967	...	61	7	11	29	84	593	696	1071	2552
		2.4%	0.3%	0.4%	1.1%	3.3%	23.2%	27.3%	42.0%	Rate 11.3
1968	...	66	9	16	28	100	632	789	1149	2789
		2.4%	0.3%	0.6%	1.0%	3.6%	22.6%	28.3%	41.2%	Rate 12.4
1969	...	64	9	13	19	71	631	792	1,158	2,757
		2.3%	0.3%	0.5%	0.7%	2.6%	22.9%	28.7%	42.0%	Rate 12.3

CAUSES OF DEATH IN ADMINISTRATIVE AREAS

	CAUSES OF DEATH	Administrative County	Cockermouth U.D.	Keswick U.D.	Maryport U.D.	Penrith U.D.	Whitehaven M.B.	Workington M.B.	Aggregate of U.D's	Alston R.D.	Border R.D.	Cockermouth R.D.	Ennerdale R.D.	Millom R.D.	Penrith R.D.	Wigton R.D.	Aggregate R.D's
	ALL CAUSES	2757	83	81	155	158	317	358	1152	26	427	238	337	154	114	309	1605
B4	Enteritis and other Diarrhoeal Diseases	3	-	-	-	-	-	1	1	-	-	2	-	-	-	-	2
B5	Tuberculosis of Respiratory System	4	1	-	1	-	-	-	2	-	-	1	1	-	-	-	2
B6	Other Tuberculosis, incl. Late Effects	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1
B14	Measles	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1
B18	Other Infective and Parasitic Diseases	2	-	-	-	-	1	-	1	-	-	-	1	-	-	-	1
B19(1)	Malignant Neoplasm, Buccal Cavity etc.	5	-	-	-	-	-	1	1	-	-	1	1	-	2	-	4
B19(2)	Malignant Neoplasm, Oesophagus	10	1	-	2	1	-	-	4	1	2	-	-	-	-	3	6
B19(3)	Malignant Neoplasm, Stomach	68	2	3	5	3	13	14	40	-	3	4	9	3	3	6	28
B19(4)	Malignant Neoplasm, Intestine	82	3	-	1	5	9	11	29	-	13	8	5	10	4	13	53
B19(5)	Malignant Neoplasm, Larynx	2	-	-	-	-	-	-	-	-	-	2	-	-	-	-	2
B19(6)	Malignant Neoplasm, Lung, Bronchus	118	8	3	5	4	24	19	63	-	14	8	11	9	3	10	55
B19(7)	Malignant Neoplasm, Breast	34	1	2	2	-	3	10	18	-	5	2	3	3	-	3	16
B19(8)	Malignant Neoplasm, Uterus	16	-	-	1	-	-	1	2	-	4	1	1	-	2	6	14
B19(9)	Malignant Neoplasm, Prostrate	17	1	1	2	2	1	1	8	1	2	-	4	-	-	2	9
B19(10)	Leukaemia	8	-	1	-	-	2	1	4	-	-	1	1	1	1	-	4
B19(11)	Other Maligant Neoplasms	137	2	7	5	11	13	18	56	3	22	7	20	7	8	14	81
B20	Benign and Unspecified Neoplasms	5	2	-	-	1	-	1	4	-	-	-	-	-	-	1	1
B21	Diabetes Mellitus	32	1	1	3	1	6	3	15	1	4	2	2	2	2	4	17
B46(1)	Other Endocrine etc. Diseases	7	-	-	1	-	-	3	4	-	1	1	-	-	-	1	3
B23	Anaemias	6	-	-	1	2	-	-	3	-	1	-	2	-	-	-	3
B46(3)	Mental Disorders	4	-	-	-	-	-	1	1	-	1	-	2	-	-	-	3
B24	Meningitis	2	-	-	-	-	-	-	-	-	2	-	-	-	-	-	2
B46(4)	Other Diseases of Nervous System, etc.	27	-	2	-	1	3	4	10	1	1	3	5	3	-	4	17
B26	Chronic Rheumatic Heart Disease	27	2	-	-	-	7	8	17	-	2	2	4	-	-	2	10
B27	Hypertensive Heart Disease	37	2	1	2	1	6	4	16	-	9	3	4	-	1	4	21
B28	Ischaemic Heart Disease	748	23	14	49	40	87	95	308	6	113	66	87	51	34	83	440
B29	Other forms of Heart Disease	116	2	6	3	6	8	14	39	1	23	13	13	4	11	12	77
B30	Cerebrovascular Disease	468	9	26	29	41	41	42	188	4	81	44	55	20	19	57	280
B46(5)	OtherDiseases of Circulatory System	139	4	2	9	8	15	13	51	1	18	18	23	5	5	18	88
B31	Influenza	39	2	1	2	1	4	4	14	1	5	3	11	-	1	4	25
B32	Pneumonia	114	2	-	3	6	15	22	48	2	29	7	14	5	1	8	66
B33(1)	Bronchitis and Emphysema	123	1	1	13	4	12	24	55	1	19	10	13	9	2	14	68
B32(2)	Asthma	5	-	-	-	1	1	-	2	-	3	-	-	-	-	-	3
B46(6)	Other Diseases of Respiratory System	38	-	1	4	-	9	6	20	-	5	1	4	4	1	3	18
B34	Peptic Ulcer	26	2	1	1	2	4	5	15	-	1	1	5	-	1	3	11
B36	Intestinal Obstruction and Hernia	11	-	1	2	-	3	1	7	-	1	-	1	1	-	1	4
B37	Cirrhosis of Liver	8	-	-	1	-	-	2	3	-	-	-	1	1	-	3	5
B46(7)	Other Diseases of Digestive System	28	1	-	1	4	3	3	12	-	9	1	3	-	-	3	16
B38	Nephritis and Nephrosis	8	-	-	-	1	1	-	2	-	3	2	1	-	-	-	6
B39	Hyperplasia of Prostrate	5	-	-	-	1	-	1	2	-	1	-	-	1	-	1	3
B46(8)	Other Diseases, Genito-Urinary System	17	2	-	-	3	2	4	11	-	-	2	1	-	1	2	6
B46(10)	Diseases of Musculo-skeletal System	9	1	-	-	-	-	1	2	1	-	2	1	2	1	-	7
B42	Congenital Anomalies	13	1	1	-	2	2	-	6	-	-	2	-	1	2	2	7
B43	Birth Injury, Difficult Labour, etc.	19	-	-	2	-	2	1	5	-	6	2	3	2	-	1	14
B44	Other causes of Perinatal Mortality	17	-	2	-	-	1	-	3	-	7	-	2	-	2	3	14
B45	Symptoms and Ill Defined Conditions	36	1	-	-	2	10	3	16	1	2	4	6	4	1	2	20
BE 47	Motor Vehicle Accidents	34	2	3	-	1	-	2	8	1	5	6	6	1	1	6	26
BE 48	All Other Accidents	64	4	-	4	3	8	10	29	-	9	5	8	2	5	6	35
BE 49	Suicide and Self-Inflicted Injuries	12	-	1	1	-	1	3	6	-	-	1	1	2	-	2	6
BE 50	All other External Causes	5	-	-	-	-	-	1	1	-	1	-	2	1	-	-	4

Year		Estimated mid-year population	Births: Number	Births: Rate	Deaths: Number	Deaths: Rate	Excess of Births over Deaths
1939	...	194,280	3,086	15.9	2,668	13.4	418
1959	...	218,900	3,888	17.8	2,611	11.9	1,277
1960	...	219,160	3,940	18.0	2,629	12.0	1,311
1961	...	221,460	3,900	17.6	2,725	12.3	1,175
1962	...	223,330	4,085	18.3	2,723	12.2	1,362
1963	...	224,650	3,964	17.7	2,813	12.5	1,151
1964	...	225,690	4,147	18.4	2,670	11.8	1,477
1965	...	225,570	3,916	17.4	2,706	12.0	1,210
1966	...	225,260	3,670	16.3	2,761	12.3	909
1967	...	225,100	3,601	16.0	2,552	11.3	1,049
1968	...	225,700	3,400	15.1	2,789	12.4	611
1969	...	224,440	3,401	15.2	2,757	12.3	644

LIVE BIRTH RATE 1954 TO 1969 CUMBERLAND AND ENGLAND AND WALES



PERINATAL DEATHS 1956-1969

Year	Stillbirths	Early Neo-Natal Deaths	Perinatal Deaths	Stillbirths per 1,000 total births		Perinatal deaths per 1,000 births	
				Cumberland	England and Wales	Cumberland	England and Wales
1956 ...	111	64	175	29.3	22.9	46.2	36.7
1957 ...	102	64	166	25.5	22.5	41.5	36.2
1958 ...	80	69	149	20.4	21.5	38.1	35.0
1959 ...	83	54	137	20.9	20.8	34.5	34.1
1960 ...	111	60	171	27.4	19.8	42.2	32.8
1961 ...	76	53	129	19.1	19.0	32.4	32.0
1962 ...	78	71	149	18.7	18.1	35.8	30.8
1963 ...	76	60	136	18.8	17.2	33.7	29.3
1964 ...	77	47	124	18.2	16.3	29.4	28.3
1965 ...	80	37	117	20.0	15.8	29.3	26.9
1966 ...	60	40	100	16.1	15.4	26.8	26.3
1967 ...	70	38	108	19.1	14.8	29.4	25.4
1968 .	44	36	80	12.8	14.3	23.2	24.7
1969 ...	47	39	86	13.6	13.2	24.9	23.4

CUMBERLAND COUNTY PERINATAL DEATHS

(locally compiled figures)

Analysis of Causes of Perinatal Deaths during 1969

Cause of Death	Stillbirths		Deaths during 1st Week	Total
	Premature	Full-term		
Toxaemia	2	2	1	5
Ante Partum Haemorrhage	5	—	2	7
Placental Insufficiency	4	3	—	7
Rhesus Factor	—	1	1	2
Maternal Diabetes	—	1	—	1
Prematurity	4	—	27	31
Congen. Malformations (including Congen. Heart)	8	4	2	14
Tentorial Haemorrhage	—	—	—	—
Asphyxia—				
Prolapse of cord	1	—	—	1
Cord round neck	2	2	1	5
Intra Uterine	—	—	—	—
Pneumonia	—	—	—	—
Anoxia	—	—	1	1
Atelectasis	—	—	2	2
Cerebral Haemorrhage	1	—	—	1
No known Cause	—	1	—	1
Malpresentation	1	2	—	3
Maceration	—	1	—	1
Post Maturity	—	—	—	—
Body of Baby Found on Waste Land	—	—	1	1
Hydramnios	—	1	—	1
Form O/S	—	—	1	1
TOTAL ...	28	18	39	85

Infant Mortality

Cause of Death	Age in weeks			
	Under 1	1 to 4	4 to 52	Total
Prematurity	27	—	—	27
Toxaemia	1	—	—	1
Congenital Malformation	1	2	—	3
Asphyxia	2	—	—	2
Atelectasis	2	—	—	2
Pneumonia and Bronchitis	—	1	11	12
Congenital Heart Disease	1	1	1	3
Gastro Enteritis	—	—	1	1
Ante Partum Haemorrhage ...	2	—	—	2
Meningitis	—	4	—	4
Rhesus Factor	1	—	—	1
Accidental Deaths	1	—	3	4
Respiratory Failure	—	1	—	1
Others	1	—	—	1
	39	9	16	64

The comparative rates of infant deaths per 1,000 total live births for Cumberland together with England and Wales for 1960 to 1969 are as follows:—

Year	Rates per 1,000 total live births	
	Cumberland	England and Wales
1960 ...	23.1	21.8
1961 ...	22.6	21.4
1962 ...	26.4	21.7
1963 ...	22.0	21.1
1964 ...	18.3	19.9
1965 ...	16.9	19.0
1966 ...	21.6	19.0
1967 ...	16.9	18.3
1968 ...	19.4	18.3
1969 ...	18.8	18.1

NURSING SERVICES

Sections 23, 24 and 25 of the National Health Service Act, 1946

"It shall be the duty of every local health authority to secure, whether by making arrangements with the Board of Governors of teaching hospitals, Hospital Management Committees or voluntary organisations for the employment by those Boards, Committees or organisations of certified midwives or by themselves employing such midwives, that the number of certified midwives so employed who are available in the authority's area for attendance on women in their homes as midwives, or as maternity nurses during childbirth and from time to time thereafter during a period of not less than the lying-in-period, is adequate for the needs of the area.

It shall be the duty of every local health authority to make provision in their area for the visiting of persons in their homes by visitors to be called "health visitors", for the purpose of giving advice as to the care of young children, persons suffering from illness and expectant or nursing mothers, and as to the measures necessary to prevent the spread of infection.

It shall be the duty of every local health authority to make provision in their area, whether by making arrangements with voluntary organisations for the employment by those organisations of nurses or by themselves employing nurses, for securing the attendance of nurses on persons who require nursing in their own home."

THE COMMUNITY NURSING SERVICES

The year 1969 has seen the further development of the community nursing teams working alongside their general practitioner and social work colleagues to provide full family care. The newer teams are seen to be maturing and the older ones in the field to be seeking and meeting new needs in the population of their particular practices, taking part in research projects, and forming new clinics for the care of patients or clients with special problems, e.g. obesity.

The necessity for on going education and special courses for the nursing staff was seen to be the main challenge to the nursing administration, and this has been carried out during the year, and has been received with enthusiasm.

In May and December a total of 34 nurses took the National Certificate for District Nursing—33 passed (30 from Cumberland) —and we are now very well on the way to a fully trained staff, including relief and part time nurses. This will be accomplished by 1970. With our increasing involvement with training and the knowledge that in the proposed new basic nurse training, student nurses would be coming for 8—12 weeks into the community, there was need to give a special course to our senior district nurses, who must play an important role in training in the field. This practical work instructors 'course was planned jointly with the Principal Tutor of the West Cumberland Hospital, and consisted of five days of lectures and discussions with special emphasis on teaching and the needs of students. Follow-up study days are planned at six-monthly intervals.

Mr. T. D. M. Holmes, Practical Work Instructor, writes:—

> "The weekly day release course gave us the opportunity to access our own standards and role as Public Health nurses in relation to our part in the training of student nurses.
>
> The fact that the course was held at the local hospital implemented the principle of two-way communication between hospital and community nursing, which is necessary for the

continuity of student nurse training, promoting a high standard of comprehensive nurse education in the future. Therefore the course was essential to pave the way to enable Public Health nurses to participate positively in the interest of student nurse training in the community."

In October a residential course was held at Underscar, near Keswick, on 'An Appreciation of Management Techniques'. Thirty-five local authority nursing staff and 1 hospital nursing sister took part—15 nurses were from Cumberland, all of whom were group advisers, or potential candidates for the grade. The course was planned jointly with the Head of the Management Services Section of the County Council. It is planned to hold follow-up study days for our staff when it is hoped to not only revise the techniques but also to see how this course has affected the management content of their task in the team.

Miss I. Arnott now Group Adviser in Penrith, remarks:—

"The course in October at Underscar, Keswick, was the first of its type undertaken by a local authority for postgraduate training. The delegates ranged through all grades of local authority nursing services: district nurses, health visitors, senior nursing officers and one lone hospital sister.

Because of the newness of the subject to most of us, the terminology at first proved rather a stumbling block and the resident team of Management Consultants proved very helpful in trying to initiate us in a very short time.

The main difficulty at first to most people I am sure was the inability to relate the content of some very excellent lectures to our own field as most examples were of industry. However, the planners had managed to offset this with speakers from our own field which helped to bring a little more enlightenment. There seemed a great deal to assimilate but the discussion groups were helpful as each person gained from the experience of staff from different local authorities doing different types of community care.

This course, while seeming to leave one floundering in a morass of ideas and new concepts proves to be, on reflection,

invaluable and for myself showed the urgent need to sit down and put my own house in order. It has become apparent that it is essential to plan an effective use of one's own time to achieve maximum efficiency."

The care and aftercare of the mentally ill is an increasing problem for the community health team and with this in mind we were pleased to accept six invitations for our health visitors to attend a two-day conference at Garlands Hospital, on 'Psychiatric Care in a Changing Society'.

Two patients were known to be receiving renal dialysis at home—the equipment needed seemed like 'science fiction' to nurses trained several years ago! A visit was made to the Royal Victoria Infirmary, in Newcastle, with the nurses concerned, and we were able to discuss with the professional units staff the implications of family stress with this treatment and also the need to train community nursing staff as the numbers of home dialysis treatments increase.

Mrs. L. Messenger, Practical Work Instructor, writes:—

"It was most interesting to be given the opportunity to visit the Kidney Unit at the Royal Victoria Infirmary, Newcastle, and to be able to see at first hand what was being done there for such patients. We also met the doctors and nurses on the unit and had a very informative afternoon.

I was also able at a later date to see one of these machines being dismantled for cleaning by a technician, but I am still not conversant with the actual workings of the machine.

Whilst realising that an essential part of the treatment is to make the patient as independent as possible, I still feel that regular visiting by a member of the family health care team is of great help."

Fourteen midwives have attended refresher courses—a statutory requirement. A series of monthly lectures has been arranged for all nursing staff, dealing with current medical and social problems.

The need is seen for continuing on going education so that the County nursing staff are up to date in modern methods of care and modern concepts of the social aspects of disease, and are using modern techniques of management as the means to achieving the best possible patient and family care. Plans are now in being for continuing this policy into 1970.

Apart from training, the other challenge was the obvious need to progress to complete continuity of care with closer and closer links with the medical, nursing and social work staff in the hospital field. The nursing officers have been forging these links throughout the years and have very good co-operation in joint training schemes, and have come to mutual understanding of each other's special tasks in caring for the community. The three area nursing officers also attend regular ward rounds and case conferences with the consultant geriatricians.

Nursing staff have been encouraged to visit and discuss with hospital staff the problems of families and environmental hazards. Many are now doing just this and we shall perhaps have a united nursing service — anyway in spirit — before the administration changes.

There is still much to be done especially for a system of planned discharge of hospital patients and a continuity of communications on patient care.

Mrs. E. M. Walton, home nurse/midwife, writes:—

> "The good relationship existing between the hospital and district staff in the Alston area, is due I think to the constant and early exchange of information about patients and also to the deep interest taken in each other's work. Each morning we visit the hospital, to which the general practitioner's surgery is attached, and discuss cases and report on patients. At the same time the hospital staff can ask for follow-up visits, to give repeat injections and treatments, or perhaps remove sutures from a patient from the Hospital's Out-Patients Department—saving a journey for a patient who may be elderly and living in an outlying farm or tied to the home with many young children—often difficult in an area with

poor public transport. If we have an elderly patient in the district becoming increasingly debilitated, living alone or with a relative needing a rest, the hospital will take him for a period of concentrated care, or on the other hand, if the hospital is hard-pressed for acute beds, I accept care of a patient at home, thus relieving a bed. We are informed of the need for a home help in good time so that this can be arranged before a patient leaves the hospital, or any other welfare support, such as meals on wheels, that may be required. We sometimes accompany a seriously ill patient in the ambulance to Carlisle when there are no trained staff free to go from the hospital, and occasionally I am on call for midwifery when there is a shortage of midwives there due to illness or holidays. Information about new treatments, drugs or trends is shared and I am informed about patients' progress and encouraged to visit frequently. As our health visitor, Miss Lockhart, can visit the area only once or twice a week, I can visit any person she would like seen more frequently—this applying especially to the maternity discharges from hospital.

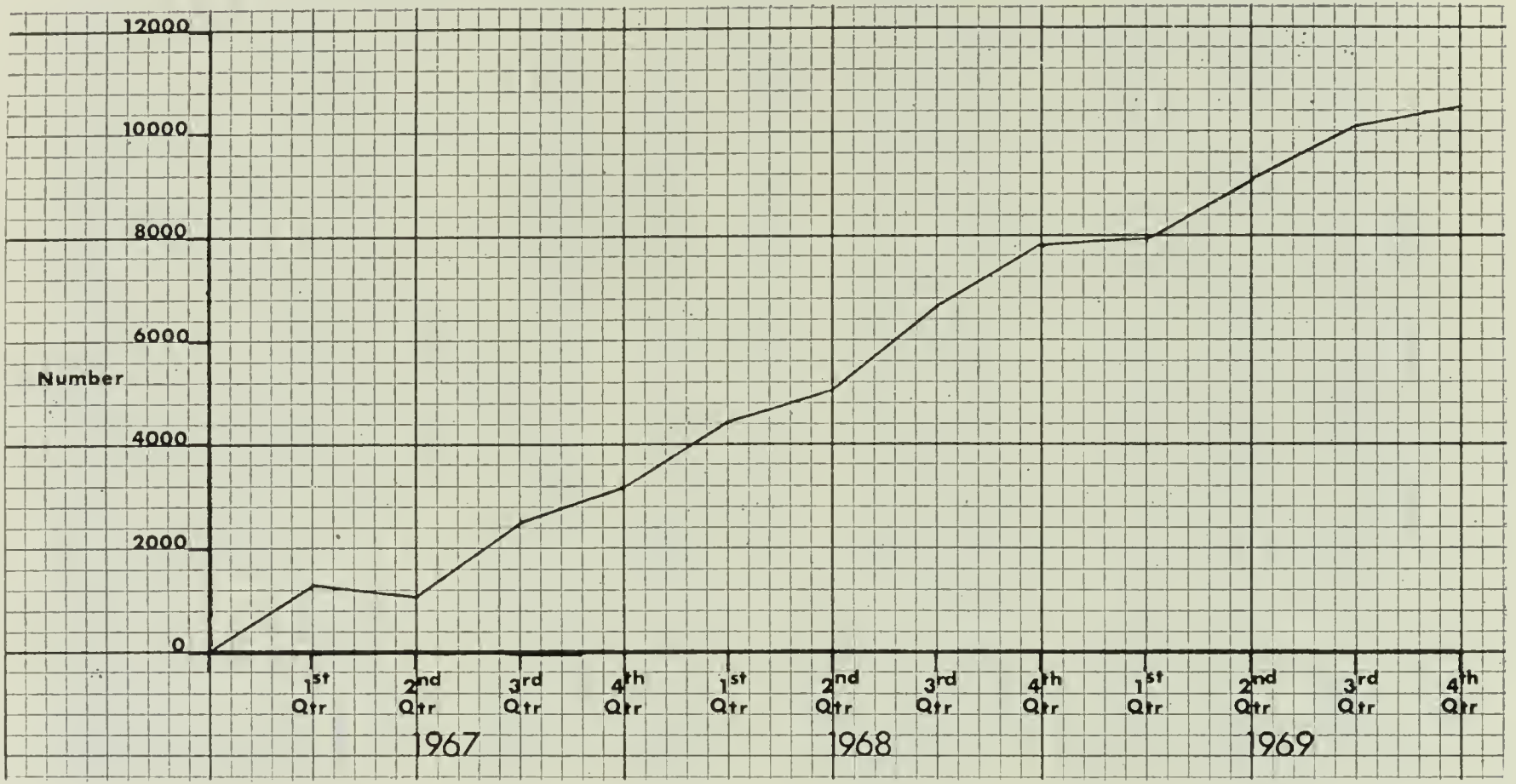
We share information about patients of mutual concern, and each arrange for the other to visit patients according to their special needs—for example, baths, foot toilet, chiropody, advice on pensions, voluntary help, clothing, etc.

We never duplicate visits and Miss Lockhart often does a call for me if she is passing a house in a remote area, to save time and mileage. We both do follow-up visits for the doctors and report back, saving their time.

All the sharing of information and interest is of great benefit to the patient in the isolated community and gives good continuity of care".

This year Miss M. Blockey, Chief Nursing Officer resigned her appointment to take up the post of Public Health Nursing Officer in the Department of Health and Social Security. Miss Blockey played a leading part in the formation of the family health care teams in the county and her appointment not only reflects great credit on herself but also on this county.

SURGERY TREATMENTS GIVEN BY NURSING STAFF



'Return to Nursing' Clubs

These Clubs continue to fulfil their very useful function and the monthly meetings are well attended by enthusiastic groups of nurses. The three Clubs—one in each county area—provide a means of bringing and keeping nurses up to date with modern trends, and are attended mainly by married nurses who hope to return to nursing when their family circumstances permit. In fact over the past few years the Clubs have provided a valuable source of recruitment to nursing posts, both in the community and in hospital.

Annual advertisements are inserted in the local press inviting any interested nurses to join the Clubs. There were a total of 73 replies to this years advertising, indicative of the continuing need for such postgraduate education for nurses. In all, since inaugurating these Social and professional clubs in 1966 there have been 269 members.

Subjects of lectures given over the year varied widely, and many were suggested by the nurses themselves. I am indeed fortunate in the willing assistance given by my hospital consultant colleagues who regularly give lectures to these nurses and to other members of my staff.

The 'Return to Nursing' Clubs are also open to any of the community nursing staff who wish to attend, and many do attend lectures of special interest to them.

Home Nursing

The changes in the pattern of home nursing which have become apparent in recent years only become clearer with the passage of time. All of these changes are in the direction of nurses operating at the qualification level they have attained rather than at lower levels of expertise. This is all intimately linked to the developments in training outlined above and the overall result is the emergence of a highly trained cadre of home nurses, state registered and post-graduate trained in district nursing leading in teams where more and more of the detailed practical nursing tasks are already being and in the future to an even greater

extent will be undertaken by state enrolled nurses or other auxiliary personnel. This evolution is necessarily rather a slow process since it often involves replacement of staff on 'turn-over' at more appropriate levels of skill. However, the position now is that in Cumberland there are 11 state enrolled nurses and 4 bath attendants functioning as members of family health care teams—figures which must increase steadily. As more practical tasks are delegated by the home nurses to auxiliary personnel so the work of the former will increasingly become more supervisory and advisory. The total volume of work is such, both amongst the elderly and others, that there will never be any question of all the nurses, home nurses, or health visitors being other than very fully occupied. However, the issue does arise for the future as to whether the answer is not a "Community Nurse" whose training would embrace much of the present health visiting training as well as that of the home nurse. This would produce an elite of community nurses to lead the teams based on group practices. I believe many general practitioners see this as the right way ahead. For my part, I see the evolution of the Community Nurse as an obvious and commendable development in the present decade.

It will be seen from the table on Page 45 (51) that both the numbers of surgery treatments and the total number of persons nursed have again risen substantially during the year; and that there has been a shift of emphasis in nursing in the home in proportionate terms from the over 65 group towards 'other age groups' the under 5 year group continuing to demand a steady 5% of the service. This shift of emphasis is not altogether easy to interpret and further observation and study over further periods of time will be required to analyse the precise meaning. One is initially prompted to comment on an altogether more systematised approach on the group practice basis to the elderly in practices with an increased efficiency in their care (including routine visiting at certain age points) and consequent reduction in the proporton of the time they demand. However, the absolute number of visits is still rising to the elderly and rather more difficult to interpret is the steeper rise in the demands on the service by 'other age groups'. This latter figure has doubled in a two year period even in the presence of a quadrupling of the number of surgery treatments in the same period. Why these age groups should require both

steeply increased services in the surgery and in the home requires further study. I am sure the answer is linked to the increasing use which general practitioners are making of nurses for repeat and follow-up visits to patients whom they have seen at home. This introduces the intriguing possibility of a joint study of the work loads of both doctors and nurses in the community. Clearly more time is available to the doctors for the practice of more satisfactory medicine in general practice. This can only strengthen the whole basis of family medical practice in this county and this may prove to be one of the most important results of the development of the family health team.

Plans are well in hand for the commencement of district nurse training for the State Enrolled nurses working in Cumberland; this training course will be run within the county and will start early in 1970. The nurses will take the examinaton of the Queen's Institute of District Nursing.

These nurses are experts in practical bedside nursing and take their place within the nursing team, always under the direction of the State Registered nurse "team leader".

Mrs. Yeomans, a State Enrolled Nurse, writes:—

"The group practice to which I am attached as a State Enrolled Nurse offers to my State Registered Nurse colleague and myself a varied and interesting selection of Home Nursing and Surgery Work. By regular visits to the older patients, care is taken not only of their physical condition, but also their social welfare. Any benefits the nurse feels will be helpful to the patients are applied for on their behalf.

Early discharge from hospital, in all age groups, are visited for the continuance of hospital treatment in the home.

At all times our doctors, who greatly appreciate the home nurse attachment, are available to us for discussion of a patient's treatment or condition.

The surgery work shared by my State Registered nurse colleague and myself, brings us patients aged from a few

months to 70 plus. Immunisation of the children against poliomyelitis, pertussis, diphtheria, tetanus and measles, dressings, cervical cytology, laboratory specimens, injection therapy for various disorders, removal of sutures, make up most of this work entrusted to the nurse.

As a member of a well-organised and smoothly running general practice, I am very happy and enjoy this branch of nursing. During the coming year I hope to qualify for the Queen's Institute Certificate in District Nursing".

The auxiliary help of bath attendants is much appreciated and it is hoped that the proportion of such workers will increase in 1970. Bath attendants, as their name implies, assist the home nurses by visiting and caring for certain patients in need of regular bathing or blanket bathing. The home nurse remains responsible for the care of these patients and continues to visit them, but, by being relieved of less technical nursing duties has more time to devote to the skilled nursing care which only she can give.

Mrs. E. J. Relph, District Nurse, Penrith writes as follows:—

"After a successful attachment of two health visitors and two district nurses to a group practice of four general practitioners we have this year had two new field workers attached to "The Team", an S.E.N. and a bathing attendant.

The State Enrolled Nurse

As our caseload steadily increased, it was decided that we should have an S.E.N. part-time to relieve days off, holidays, and give extra help, one day a week.

Our new nurse, an S.E.N. trained in West Cumberland, had not had previous district nursing experience, but proved to be keen, interested, enthusiastic, willing to learn, and a good team worker.

My fellow district nurse and myself gave her case histories, any information available belonging to each case—support

and counselling was always readily given—case discussions were frequent—and a good friendly relationship existed.

The general practitioners to whom we were attached accepted the nurse well, and she was included in case discussions, with general practitioners/health visitors/district nurses. Her recent hospital experience helped her to make valuable contributions to these sessions.

As the year has passed our S.E.N. has worked along with us. We have become a "good team", working well with the general practitioners, giving a good smooth nursing service and getting real job satisfaction.

The S.E.N. has proved her worth in general practice.

The Bathing Attendant

The review of the increasing caseload of the district nurse, revealed that much of her time was consumed in bathing the aged, a very essential service, but one which it was felt could be delegated to a "bathing attendant" who could work along with the nurse.

In due course, our bathing attendant, a kindly sensible person, with some nursing experience and a grown up family of her own was "attached" to us, and she also, has proved herself a willing capable member of the team.

After initial visits with the district nurses to various types of patient, for bathing sessions, our new "bathing attendant" was given a weekly "bath list". A certain amount of medical information, facts regarding the patient, and his known conditions were given to her, together with the assurance that any appeal for information, help, advice or support would be readily available at any time. She has now been accepted as part of the team, by general practitioners, patients, and ourselves, and is proving herself in general practice."

	1967	1968	1969
Surgery Treatment per year	8,007	23,935	37,639
Home Nursing			
Total no. of persons nursed	6,331	7,891	10,155
Aged under 5 years	361 (5%)	414 (5%)	579 (5% of total)
Aged over 65 years	3,516 (56%)	4,153 (53%)	4,639 (46% of total)
Other age groups	2,454 (38%)	3,324 (42%)	4,939 (49% of total)
Total no. of nursing visits	172,415	177,360	197,590

Increase in visits to 65 plus and other groups

	1964	1965	1966	1967	1968	1969
Over 65's visits	73,965	97,834	107,933	113,747	130,979	146,107
Other groups	60,340	52,822	54,051	58,668	46,381	51,483

Marie Curie Memorial Foundation

Help from the Marie Curie Memorial Foundation is available to all cancer patients and may take the form of a welfare grant for extra comforts, or nursing care through the Day and Night Nursing Service. The Marie Curie nurses may be State Registered, State Enrolled or auxiliary nurses—occasionally home helps may be employed under this scheme as 'night sitters'.

Welfare grants may be given for the purchase of such "extras" as coal, special foods and blankets— in fact, for anything which may make the patient more comfortable. In all, 11 patients were helped by such welfare grants in 1969, the majority of such grants being for clothing and bedding.

The Day and Night Nursing Service gives help as necessary to relatives nursing a cancer patient through a terminal illness, and is additional to the nursing care which is given by the district nurse.

Relatives caring for a loved one day and night become very much in need of rest and help, and this is where the Marie Curie Nursing Service can be of great value. The relatives can have a good night's rest secure in the knowledge that the sick person is well cared for.

It seems very significant that out of some 500 deaths in Cumberland from some form of cancer during 1969 only in 7 cases was advantage taken of the Marie Curie Nursing Service. This is in addition to the 11 patients mentioned above helped by way of welfare grants. Just over 200 of these cancer deaths occurred at home and it is difficult not to feel that many more could have benefited from the assistance offered by this special nursing help. Similarly one wonders whether some of the deaths whch occurred in hospital might not have occurred at home to the greater comfort and satisfaction of all concerned through this special nursing help which is available. While some families would appear to wish to give continuous and exclusive attention to their relatives in a terminal illness many others must know considerable distress from limited access due to terminal hospitalisation. Clearly some of the latter cases must be in hospital but a wider intermediate field such as the Marie Curie Foundation seeks to help, surely exist. I would hope to see a wider take up of this fine service in the future.

Since November, 1965 there have been 30 nurses accepted for Marie Curie work, with 8 new appointments during 1969. This involves a considerable amount of work in appointing such staff when only a comparatively small number are actually employed (6 during 1969). However, as these nurses are mostly housewives with home commitments it is necessary to have a large "pool" to draw on so that urgent requests for help can be met immediately.

Some Marie Curie nurses eventually come on to the county staff as relief or part-time workers and provide a useful "reserve" to call on in emergency.

I inserted the following paragraph in the Bulletin to General Practitioners in January, 1970:—

> "Money is available from the Marie Curie Fund to provide extra care and comfort for cancer patients being nursed in their own homes. This care may take the form of full nursing help or, in appropriate cases, of the services of a "night sitter" or home help. Such service is free to the patient's family and I feel sure that greater advantage could be taken of this service.

In the last twelve months 210 patients have died of cancer in their own homes and of this number only 7 have received this help. If doctors wish to take advantage of the scheme in any particular case they should ask their nursing staff to be in touch with the Area Nursing Officer".

The following table shows the use made of the Marie Curie Service over the past three years:—

	1967	1968	1969
Welfare Grants	15 patients	9 patients	11 patients
Nursing Service	7 patients	8 patients	7 patients

Midwifery

The tables below present the basic statistics of this service during 1969:—

Year	Total Births	Institutional	Domiciliary	Domiciliary Percentage
1966 ...	3,719	3.158	561	15
1967 ...	3,662	3,234	428	12
1968 ...	3,448	3,147	301	9
1969 ...	3,480	3,254	226	6

Home confinement rate in each area:

	1967	1968	1969
Western Area ...	9%	6%	4%
Southern Area ...	14%	10%	7%
Northern Area ...	12%	10%	6%

Clearly the critical facts are the reduction in the percentage of home confinements in the county to the all time low of 6% with the far more dramatic figure of 4% in the Western Area. My recent annual reports have all high-lighted the various aspects of this problem namely the near impossibility indeed of maintaining an adequate domiciliary midwifery service for so few mothers in an area of such scattered population. The following table shows that 1969 has seen yet a further reduction in the number of domiciliary midwives, both in terms of individual and full-time equivalent:—

	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969
Domiciliary Midwives	74	66	73	74	69	49	40	36	36	33
Full-time Equivalent	44	39	44	43	22	19	14	13½	11½	8
Institutional Midwives	42	44	53	55	60	59	50	53	56	62

Each year it seems impossible that the number of domiciliary midwives can fall any lower and indeed it was the urgency of the situation in the Western Area which made it imperative in 1969 to ensure the introduction of a hospital-based agency service for domciliary midwifery in the area of Workington and its immediate surroundings. A further comment appears on this below.

During 1969, 657 expectant mothers were given antenatal examinations by domiciliary midwives, at antenatal clinics held either in general practitoner surgeries, or county clinic premises but only 236 mothers attended for post-natal examinations at these special clinics. The number of antenatal visits paid to mothers in their own homes was 5,346—an increase of 280 over the last year's figures.

The midwives paid 4,492 visits to mothers confined in their own homes which is a decrease of 1,244 visits from the 1968 figure. The number of visits paid to mothers who were discharged before the tenth day increased, however to 4,630 from 3,866 in 1968; of this figure 146 were paid to patients discharged within 48 hours, and 1,117 patients discharged between the third and eighth day.

The data given in the above two paragraphs are broadly in keeping with the general trend away from home confinement, but in which the greater part of the routine antenatal care for hospital booked mothers continues to be carried out by general practitioners and their domiciliary midwives. The general movement towards earlier discharge from hospital is also observable in the figures.

I must also record that the number of 'high risk' cases booked by their general practitioner for home confinement remains disturbingly high. Of the total of 226 domiciliary confinements in 1969, a total of 35 were clearly 'high risk' cases in terms of age,

parity and/or previous obstetric history. The fact that these cases are mostly associated with a very limited number of areas and practices does not lessen my anxiety about the part which the domiciliary midwife is asked to play in them. Some of these mothers were only referred to the midwives at three months or less before the expected date of delivery leaving quite inadequate time for good antenatal care or satisfactory essential health education. No doubt some of these cases were also late bookers as far as their doctor was concerned. Of the 35 'high risk' mothers booked for home confinement 7 were eventually admitted to hospital and I give below some details of these cases:—

1.	With toxaemia and overdue by dates	live delivery
2.	Post mature (mother aged 39 years)	live birth
3.	Abnormal presentation (mother 37 para. 2)	still birth
4.	Ante partum haemorrhage (primigravida—aged 17 years)	live birth
5.	Premature labour (primigravida—aged 21 years)	live birth
6.	Transverse lie (para. 6)	live birth
7.	Intra-uterine death	still birth

Inclusion in the 'High Risk' category may be on account of any or all of the following:—

(1) Parity—(a) primigravida
(b) fourth and subsequent pregnancies.
(2) Age—mother over 35 years, or under 18 years.
(3) Previous obstetric history e.g. previous post partum haemorrhage.
(4) Medical conditions e.g. patient with heart disease.

Year		'High Risks' cases	Domiciliary Births	Percentage
1963	...	48	982	5%
1964	...	147	888	17%
1965	...	84	711	11%
1966	...	64	561	11.5%
1967	...	37	428	8%
1968	...	32	301	14%
1969	...	35	226	15%

The table shows that as the percentage of mothers confined at home drops the proportion of 'at risk' cases does not decrease proportionately. This is possibly because the very mothers who are most at risk are those who are the most anxious to stay at home for confinement. It is difficult to explain to a mother who has had three easy normal confinements that it will be necessary for her to go into hospital for future confinements. Not included in the above 'at risk' categories but very much at hazard in my view, are those mothers living in isolated houses many miles from the nearest obstetric unit. Should difficulties arise during labour it may be difficult to get help to them quickly.

Reverting to the subject of agency arrangements for the conduct of domiciliary midwifery in the Workington area, I am glad to be able to report on the satisfactory operation of this pilot scheme which came into operation on 1st June after many hours of discussion with the consultant obstetricians, hospital midwives and general practitioners in the Workington district. I am particularly grateful to the West Cumberland Hospital Management Committee and the obstetric staff of Workington Infirmary for their co-operation. The scheme may be summarised as follows:—

1. The Hospital Management Committee undertakes to act as agents of the Cumberland County Council for domiciliary midwifery attendance at confinements in the Workington area.

2. A set of case notes are provided for the hospital midwife and these are held at the hospital readily available for the midwife who is called to a confinement.

3. The hospital midwives aim to carry out three antenatal visits and one post natal visit, one of which will preferably be in company with the domiciliary midwife employed by the County Council for the purpose of handing over information and, if possible, one of the antenatal visits should be at a general practitioner's session. The others will be at the patient's home.

4. The hospital provides midwifery packs and such other items as may be agreed from time to time.

5. Portable equipment previously used by the domiciliary midwives has been transferred to the hospital.

6. Hospital midwives engaged on domiciliary midwifery can use their own cars and will be reimbursed at the casual user rate for the time being allowed by the County Council. In some cases the ambulance service may be summoned and Distington Ambulance Station will be instructed to treat these calls as emergencies.

7. The hospital midwives do not go to the patients' homes in uniform but protective clothing in the form of the overalls now provided for domiciliary midwives employed by the County Council is worn over ordinary clothing.

8. The County Council has made arrangements to indemnify the Hospital Management Committee against all costs, claims, damages, expenses and proceedings arising out of hospital staff undertaking domiciliary midwifery work.

9. As it will not be necessary to supplement the existing staff at the Workington Infirmary to enable the domiciliary midwifery work to be carried out, the Hospital Management Committee's charge to the County Council is based upon actual cost.

A financial agreement was reached between the County Council and the Hospital Management Committee based upon these costs and the amount of time spent by the midwife.

Miss Blake, Superintendent Midwife, Workington Infirmary has played a key role in the planning and operation of the scheme and I am indebted to her for the following account:—

> "As from the 1st June, 1969 the Workington Maternity Department have acted as an agency for the confinement of patients in their own homes in the Workington area.
>
> This we looked upon as a challenge to provide an efficient service from within the hospital and many problems had to be encountered. Once the wheels were set in motion everything has gone along quite smoothly.
>
> We acquired all possible equipment from the domiciliary midwives and to bring us up to date with modern techniques we purchased Ambu bags for the resuscitation of the newborn

baby. The delivery packs are made up to our specification in C.S.S.D. at West Cumberland Hospital and apart from gowns, dressing towels and instruments all items used are disposable. This we find a great help to the patient who now only has to supply for the confinement, hot water in in addition to preparing the room and baby's requirements.

The hospital midwife meets the patient for the first time at 36 weeks gestation, usually in the doctor's surgery at a routine ante-natal visit. She then makes arrangements to visit the patient at her own home each week until the confinement takes place. A return visit is made followed by one post-natal visit prior to handing the patient back to the domiciliary midwife. Modes of travel for the midwives vary. A few are car owner drivers and others have to rely on the ambulance and taxi services, and the energetic do nearby visits on foot.

One aspect we were a little concerned about was "continuity of care", realising that the patient really got to know her own district midwife and, therefore, had acquired great confidence in her. So far we have had only favourable comments from patients about the repeated change of faces, as unfortunately we cannot guarantee one patient one midwife.

There were 12 home bookings up to the end of 1969. 7 were delivered in their own homes and the remaining 5 confined in hospital.

Of these 5, one patient had to be admitted in labour as on this occasion there was no available midwife for domiciliary cases, owing to the pressure of work on the Department.

The other 4 were admitted during the ante-natal period for obstetric reasons.

(a) Primigravida at term, contracted outlet. Instrumental delivery.
(b) Gravida 2. Post-maturity for induction of labour. Delivered by ceasarean section.

(c) Gravida 3. Terminal hypertension for induction of labour. Delivered spontaneously and discharged home on her fourth day.
(d) Gravida 2. Hypertension and twin pregnancy. Transferred to consultant care and delivered in hospital.

There was 1 "at risk" patient delivered at home. A gravida 8 who had a normal labour and delivery without complications."

Of the two midwives who had carried on the midwifery services in the town, one is still involved in ante-natal clinics run by the general practitioner for hospital booked patients, in some maternity nursing and also for the follow up of non-attenders to general practitioner and hospital ante-natal clinics, the follow-up mothers needing observation at home, i.e. hypertensives etc., and the running of relaxation classes with the hospital midwives.

The other district nurse/midwife is now only doing the little midwifery care needed in the particular practice to which she is attached and acting as relief for the other nurse.

There is no 24 hour 'on call' system for these domiciliary midwives now.

I am indebted to Mrs. M. K. Tunstall, home nurse/midwife, for the following account of her work:

"As a district midwife of 17 years, with a love for my job, I was very horrified several years ago to be told by my County Medical Officer of the "Wind of Change" which was blowing through my profession. Together with the majority of my district colleagues, I could not believe that this would really happen.

After the Ministry reports and peri-natal surveys recommending more rigid selection for home-confinement, and in our area, greater availability of hospital beds, I began to feel the cold breath of this "wind". Press and television gave much publicity to this, with one result, that patients and general practitioners alike tended to favour more and more

hospital confinements, even for patients who came into the "safe at home" groups. Nowadays the young mothers are just given appointments for hospital and take it for granted.

Many of us "old stagers" were vociferous in our objections at meetings, as we felt that the personal touch was going from midwifery, together with continuity of care. We eventually realised we were wasting our time and had to start thinking of other ways to use our hard earned skills.

There are still a few mothers who will not go into hospital but not enough to give job-satisfaction to full time midwifes. It was economically unsound to have a staff of full time district midwives to cover this small number. Now, I see these patients at the ante-natal clinics, inspect their homes, help them with preparation, and the hospital midwife takes over at 36 weeks and delivers them. I follow on the next day and carry on with post-natal care. I have very good liaison with the hospital and often visit these girls in labour and durng the post-natal period.

Together with a hospital midwife, I attend the mothercraft and relaxation classes at the hospital, and the mothers who are general practitioner bookings like this arrangement very much.

I also attend early discharges from hospital. The consultant obstetrician here does not like patients to go home early, but we do get a few. I check blood-pressures for the hospital and round up defaulters. In these various ways, we are getting a lot of health education over to these mothers.

The thing I miss most is following these patients through their labour and delivery and I have a certain feeling of frustration because of this. Although this is not everything, mothers learn to have confidence in the midwife they are seeing all the time. The ideal in many respects would be for the midwife to go to hospital with the general practitioner and deliver the patients together. A retrograde step in my opinion would be for more fortyeight hour discharges, as the patient then would have more people looking after her and would be more confused.

Mothers have asked me if everyone now has to go in to hospital, and I tell them they still have a freedom of choice, if everything is satisfactory. One mother even asked me if I was 'not qualified to deliver babies"!!

In conclusion, I have now better hours of work, and am better able to plan my work and I can devote more time to antenatal care and teaching. On the other hand, I feel something is lacking, and I am sorry that the new pupil-midwives are not going to see so much normal midwifery carried out in the happy atmosphere of the mother's own home".

The thoughts expressed by Mrs. Tunstall must be common to many domiciliary midwives who have in recent years seen their work change so drastically. Their disappointments and concerns are very understandable and their remarkable adaptability highly commendable.

There is no doubt in my mind about the pressing need for further extension of agency arrangements with the main hospitals in the county in 1970 for the conduct of the ever-dwindling number of home confinements. I have taken the initial steps in the East Cumberland area though I would anticipate that the most immediate next move would be an extension in West Cumberland of the already successful scheme now operating in Workington.

The other development in midwifery during 1969 in which the local authority service has been closely involved was the introduction of an integrated midwife training scheme whereby a single unified training fits a midwife for hospital and domiciliary practice. This unified training replaces the old Part I and Part II trainings. The major role which the local authority services play in this new training is in fact in introducing midwives in training to community medical and nursing practice as it exists today. The student midwife spends three months 'on the district' learning about community services as well as taking part in the care of midwifery patients. Of the first 5 students taking the course all have passed their final examination and are now state certified midwives.

Mrs. Lancaster, a teaching district/midwife (who is also a district nurse and health visitor) reports:—

"Regarding my role in the training of the pupils undertaking the new course, the main part of the workload was ante-natal and post-natal care in the home, and in the group practice surgery. This gave the pupils much more confidence in the examination of the expectant mother; this confidence she was unable to find in hospital because of the pressure there. The general practitioners welcomed the pupils into their surgery and appreciated the opportunity of teaching.

My post being that of district nurse/midwife meant that the pupil spent part of the day doing many generalised duties. Domiciliary confinements were few and as we all know are likely to decrease further. Therefore I feel the new training gives the pupil a broader based training; her wider knowledge should help her to deal more easily with domestic situations, enabling her to become a well informed member of the health team."

I believe Cumberland to be uniquely situated to offer these midwives in training a thoroughly sound experience of community medicine while they are out with the community nursing staff and observing the work of group practices and the whole family health care team.

Again the perinatal death rate of 24.9 is relatively low, and there have been no maternal deaths during the year. Various factors contribute to this, the main ones being:—

(1) a high rate of hospital confinement (93.5%) and the continuing efficiency of the obstetric units in the county;

(2) the high standard of antenatal care throughout the county;

(3) efficient transport of newly born infants requiring special care to paediatric units in this and other counties.

Notifications of Congenital Abnormalities

The scheme introduced by the Ministry of Health in 1964 for the notifications of congenital abnormalities has continued in operation and in 1969 there were 49 notifications compared with 56 in 1968. I commented last year on my concern that **all** cases should be notified and indicated that an investigation was proceeding based on a research project undertaken by the Registrar General. This latter had shown that in 1966 there was some evidence that certain authorities of which Cumberland was one, were not achieving truly comprehensive notification without which the scheme lost a great deal of its effectiveness as an early warning system of drug, disease or other factors which might be causing malformations. Detailed investigation of this situation in which the hospital maternity departments, the main suppliers of information, co-operated fully showed that in the year which had been studied a few cases had apparently been missed in this area, sufficient to affect the relevant figures. However, the reassuring fact which emerged was that all subsequent years' data indicated that any faults had been corrected and that the notifications were now coming through comprehensively. It was universally appreciated that this happy situation would only be maintained by unfailing vigilance on the part of all the midwives with responsibility for notifications.

The following table gives a breakdown of the total congenital malformations notified since 1964.

	Males		Females		Total	
	Live Births	Still Births	Live Births	Still Births	Live Births	Still Births
Total cases notified	149	27	134	39	283	66
Central nervous system ...	24	24	31	36	55	60
Eye, ear, etc.	4	—	4	—	8	—
Alimentary system	17	—	13	2	30	2
Heart and great vessels ...	6	—	5	—	11	—
Respiratory system	1	—	1	—	2	—
Uro-genital system	32	—	1	—	33	—
Limbs	47	—	55	—	102	—
Other skeletal	4	—	1	—	5	—
Other Systems	9	1	8	—	17	—
Mongolism	3	2	12	—	15	2
Other malformations ...	2	—	3	1	5	1

Prematurity

A premature infant is a live born infant with a birth weight of 5 lbs. 8 ozs. (2.5 kilogrammes) or less.

The percentage of premature live births of total live births is 5%.

Premature births notified during 1969 as set out below with the previous four years for comparison.

1. Number of premature live births notified:—	1965	1966	1967	1968	1969
(a) in hospital	196	218	222	212	178
(b) at home	17	22	10	19	9
(c) in private nursing homes ...	—	—	—	—	—
	213	240	232	231	187

2. Number of premature stillbirths notified:—					
(a) in hospital	51	34	51	31	22
(b) at home	3	3	3	1	—
(c) in private nursing homes ...	—	—	—	—	—
	54	37	54	32	22

There was a total of 9 premature babies born at home during 1969 compared with 20 during 1968 of these 7 survived.

Premature Births

Weight at Birth	LIVE BIRTHS												Stillbirth	
	Born in Hospital				Born at home or in a Nursing Home: Nursed entirely at home or in a nursing home				Born at home or in a Nursing Home: Transferred to Hospital on or before 28th day					
		Died				Died				Died				
	Total Births	Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days	Total Births	Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days	Total Births	Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days	In hospital	At home or in a Nursing Home
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
1. 2 lbs. 3 ozs. or less ...	12	8	3	—	1	1	—	—	1	1	—	—	8	—
2. Over 2 lbs. 3 ozs. up to and including 3 lbs. 4 ozs.	12	6	1	—	—	—	—	—	1	—	—	—	4	—
3. Over 3 lbs. 4 ozs. up to and including 4 lbs. 6 ozs.	39	2	3	—	—	—	—	—	1	—	—	—	6	—
4. Over 4 lbs. 6 ozs. up to and including 4 lbs. 15 ozs.	22	1	2	—	1	—	—	—	1	—	—	—	1	—
5. Over 4 lbs. 15 ozs. up to and including 5 lbs. 8 ozs.	93	1	1	—	3	—	—	—	—	—	—	—	3	—
6. Total	178	18	10	—	5	1	—	—	4	1	—	—	22	—

HEALTH VISITING

The recruitment of health visitors has remained the only problem in the filling of vacant community nursing posts and this branch of the nursing service has been two to three under establishment for the past year. The Council has awarded three health visitor scholarships during the year, and two of our own staff who are at present students will be joining us trained in the summer of 1970. The scholarship scheme will thus be seen to some extent to alleviate the problem of understaffing.

The continued increase in the number of clinics linked with general practices bears witness to the success and acceptance by the general practitioners of the community nursing organisation and has provided some interesting developments in the preventive aspects of disease.

The existence and day by day functioning of the family health team has become so securely established now in Cumberland that one almost tends to forget the great amount of labour and reorganisation which went into achieving this major historical realignment of the community nurse's work. The health visitor has always been in the forefront of this and some of the interesting, and in my opinion far reaching developments described below could not have begun with any real hope of success in any other setting than that of the family health care team. It is most encouraging that health visitors in group practices are taking up these new ideas with such wide enthusiasm, supported, and increasingly led, by the family doctors. It was some two years ago that I first implanted the idea that a visit should be planned to all elderly people at about the age of 75; the teams of nurses with the general practitioners in the practices being encouraged to plan and pursue this matter as far as detail was concerned according as was thought best in the circumstances of the practice. Similarly with cervical cytology the development and streamlining of this service by the doctor/nursing team on a practice basis may well be the foundation for more extensive screening activities in the future.

Cervical cytology sessions have started in several areas, which has brought the health visitor into contact with a new age group.

The health visitor is able not only to screen for cancer of the cervix but also to allay anxieties on minor gynaecological troubles, advise in certain marital difficulties, or refer patients to the appropriate agency.

These sessions have also on occasions become general health education sessions. I would like to thank Miss S. Twigg for her comments on the cervical cytology service offered in a Maryport group practice.

> " 'Friendly persuasion'—that is the only way I can describe my efforts to get the mothers to attend the cytology clinic. The age group is 35 years to 50 years—I delivered many of their babies and I am now visiting their grandchildren. During my routine visiting, where possible, I always bring up the subject of cytology and my advice is often sought about vaginal discharges, irregular periods, etc.
>
> It is astonishing how many are frightened to attend the clinic. I try to dispel these fears. One of the doctor's referrals is mothers on 'the pill'—indeed the doctors use the clinic for many reasons and the appointments usually coincide with their appointment with the doctor during surgery.
>
> We have an arrangement that if there is any query about a vaginal discharge I take a high vaginal swab. Any of the doctors will examine a patient if I am unhappy about the condition of the vulva, vagina or cervix.
>
> The appointments are made by the receptionist and are every 15 minutes. I prepare most of the clerical side and writing of slides before the session; otherwise I could not manage. There are only minor delays, waiting for the doctor, or a patient failing to come at the appointed time.
>
> Defaulters I follow up by visiting. It is only if I cannot contact them that I write. I visit if there is any adverse report and they have to see the doctor. Each doctor has his own method where there is definite Trichomonas seen. I see both the husband and the wife if I am asked to. One doctor gives me the prescription too. Only two patients have

failed to return for a repeat smear. One woman said to me, with a smile, "You don't let up, do you?".

We have a fortnightly clinic, 1.30 p.m. to 6.25 p.m. and the overall figure for 1969 was 211 an average of 4 or 5 per week. There is good co-ordination between the group practice and myself on this matter. I have not many more months to work before I retire, but I should like to continue in this field of preventive work. I am interested and it gives me great satisfaction."

In Workington it is of interest to see that two health visitors have succeeded in co-operating with employers and the occupational health nurses and have been able to arrange sessons at some factories for cervical screening. Miss G. Davies and Miss A. Jackson, health visitors, have kindly contributed the following account.

"In 1967, Miss Jackson and I got the idea that the women working full time in factories were not taking advantage of our local authority cytology session. This, we thought, was a great pity and so we decided to take our service to the factories! The way we jointly planned and provided the service may be of interest.

First we made an appointment to meet the chief nursing sister at a steel works. She was very enthusiastic about it and, at the same time, we met some of her nursing staff and saw their little 'health centre', which was ideal for a cytology session. After sister for the approval of the management, she arranged a list of some 25 to 30 women, and we agreed on a date and time. We took our equipment with us in the county van and it was very gratifying to find that the nursing sisters themselves were 'first on the list'—very noble! They then acted as runners for us so that little time was wasted and we merely did the actual clinical work. The following year we were invited back again to conduct another session, and on this occasion the Works' medical officer came to meet us and thanked us for our "valuable service". Our next project was at a laundry. We made an appointment to

see the Manager. He was very courteous and interested, and although he had no facilities on the premises for us to hold a session, he was indeed most co-operative. He arranged with his lady welfare officer to give the women an extra tea-break to allow us to give a talk to them on cytology. At the end of the talk we took names and arranged a special session at Park Lane Clinic to suit these ladies.

At the end of 1968 we met the nursing sister of a cloth factory, at a nurses' study day at Workington Infirmary, and interested her in holding a cytology session in her 'surgery' at the factory. After she had discussed it with the management—who thought it was an excellent idea—we went to view the 'surgery' and discussed the planning of a session. Here we had to make some small adaptions—their electric plugs were different to ours so their electrician made us an adapter to accommodate our equipment. The couch was too low, so we decided to use a table! At this factory, the men and women work closely together, so our next problem was how to let the women know about our intended session with the least possible fuss and to avoid any embarrassment. We put forward some suggestions and, here again, the management were very co-operative It was decided that a little notice would be put into each woman's pay packet, calling them to the Canteen for ten minutes in four groups. We gave a talk to these groups and arranged dates and times for two sessions at their factory 'surgery'. At both these sessions the nursing sister acted as runner for us, so again things ran smoothly with no wasted time.

At the first session a 48 year old woman came forward (who incidentally had a negative smear taken two years ago) and before we returned a week later to do the second session her report came through to the family doctor to whom I am seconded, stating "typical basal cells" and requesting a second smear. I was able to discuss this with the doctor and did, in fact, arrange to take the repeat smear at an evening surgery in the presence of the family doctor. Within another week this lady was in hospital having treatment. It was also discovered that she had an anaemia, which was rectified. With

in a short time she had a total hysterectomy and was able to return to work. She had not any symptoms of illness and I know she is very grateful to the liaison between factory/family doctor team/hospital on this occasion.

At the end of each of these sessions we both had a deep feeling of satisfaction, not just with the work done, but with the extraordinary good relationship we achieved with the nursing staff and the management of these factories.

We have been invited back to the cloth factory and steel works again this year."

Health visitors have also assisted in general practice research projects and I am indebted to Mrs. M. E. Dobson who, having taken part in two such projects, has provided the following account:—

The general practitioner kept a record of each patient who either visited him in his surgery or who had a home visit, with details of type of visit, time spent with patient and travelling time. A similar record was kept by the district nurses, midwives, health visitors and home helps. The staff of the City Health Department were also involved. All the information gained has been fed into a computer in Newcastle and the results will be published in due course.

Another survey was designed to pick up all under the age of 18 years, in one urban general practice, who might have a symptomless bacteriuria, the total number of children being between 900-1,000. Originally it was planned to screen 20 per week but this was not practicable. Between 8 and 12 children were screened weekly amounting to about 150 by the time the flu epidemic made it impossible to continue, but the survey will continue in the Spring.

The methods employed were routine testing for sugar and protein and microscopy in the surgery: centrifuged urines were examined for the deposit and colour count in the laboratory. A dip slide was also sent to the laboratory and the specimens collected fresh in the surgery and refrigerated before transport.

The conclusions reached so far are that only fresh specimens refrigerated at once are of any value and that the dip slide is an easy and accurate method for screening urine in general practice."

Turning to the matter of the regular care of old people, I am indebted to Miss D. Roulstone for the following account:—

"Doctors in a practice in Penrith are now offering their patients aged 65 years and over a simple medical check whereby the vision, hearing, urine and blood pressure are tested, and the blood tested for anaemia. The tests are entirely voluntary and are carried out by the health visitor attached to the practice.

The scheme was introduced as the doctors felt that some old people were reluctant to trouble the doctor. In some cases this was due to accepting ailments as a part of growing old, and in others they were unaware that there was anything wrong with them. Many old people suffer disabilities such as defects in hearing and eyesight without complaining. In certain cases these defects can be helped. The doctors felt that the health visitor, who was in close contact with this group of people, would be a very suitable person to carry out the tests. In addition it could make the health visitor's work more interesting. So far, the tests have been carried out in the home. Testing began after Christmas and quite a number of patients were found to be away visiting relatives. Of the first 11 patients offered the tests, two refused. It is interesting to note that of the 9 patients actually tested, two had previously undetected sugar in the urine and two others had a trace of albumin. One of these also had anaemia. Two patients had had their glasses changed at least three years ago, and it was suggested that it would be advisable for them to have their eyes examined by their optician in case their spectacle lenses required changing. One patient examined was subsequently referred to an eye specialist. In the case of any abnormality the doctor carries out further tests.

In future there is every hope that the more able members in the selected age group will attend the surgery for the

tests after receiving an explanatory letter and an appointment. A greater number of patients will then be able to be seen in a shorter time and the results of the scheme assessed. Patients unable to attend will of course be visited at home".

Yet another function of the health visitor is the socio-medical assessment of the over 75 year olds, and I would like to thank Miss J. M. Crossfield, Western Area Nursing Officer, for the following report:—

"In 1969, 120 persons were interviewed and the following facts emerged:—

1. Males: 53—6 living alone

   Females: 67—33 living alone.
   This follows the normal pattern of women having a higher survival rate than men and also that they would seem to be able to live alone more easily.

2. Married: 55

   Widowed: 55
   Single: 9
   Separated: 1
   I was surprised to find that almost half are living with their spouses. I had expected this figure to have been much lower.

3. Living alone : 39

   Living with family : 25
   Living with friends : 1
   Part III Accommodation : 2.
   These figures total 67 persons, leaving 39, or 38.2%, married couples living in their own homes. The widowed, single, and separated account for 65. 39 of whom live alone, which is 60% of these, and 32.5% of the total interviewed.

4. Type of Dwelling

   House : 104
   Flat : 6

Bungalow : 7
Public House : 1
Part III Accommodation : 2
The type of accommodation available in the area is reflected here, and could point to the need for more flats and bungalows.

5. Illnesses reported as being severe enough to have some effect on the person's daily activities were:

Epilepsy	1	Bronchitis	6
Duodenal Ulcer	2	Cardiac Diseases	7
Hypertension	3	Carcinoma	3
Arthritis	17	Phlebitis	1
Diabetes Mellitus	3	War-wound Leg	1
Hemiplegia	4	Amputation Leg	2
Mental Illness	3		

As would be expected, arthritis, bronchitis and cardiac illnesses make up the greatest number. If a person had more than one disability, only the major disability was listed. This gives a total of 57, or 47.5% of the total.

6. Loss of hearing : 6
Loss of vision : 11
These are significant losses, sufficient to cause hardship.

7. Specific needs listed which were required:
Home Help : 1
Bath Rail : 1
Re-housing : 4
These are very few in number (see note 8) but many forms indicated that there could be a need for help in the near future.

8. Social Services:
The forms used do not ask for details of any services being received, so there is no way of recording this.

Conclusion:

The survey is for individuals of 75 years of age, and the form is a simple one, merely asking if the person is adequately cared for, and what help is required, if any.

Fifty-seven persons have some debilitating medical condition, plus 17 with hearing or visual defect. Twenty-five individuals live with relatives and it is the 39 living alone who are at the greatest risk. Although these forms do not produce many cases for immediate action, their use provides an excellent means of bringing to the notice of the nursing staff the persons 'at risk' in the community and also inform individuals how to obtain help. For these reasons I feel they are well worthwhile. If it is felt desirable to know at a glance what help is already being given to this age group, the form will have to be re-designed. At the same time, I would not like to see it become complicated to such an extent that the interviewer would need to produce it in the house and ask detailed questions, as this, I feel, might cause suspicion and upset the relationship between the health visitor and the person being interviewed. This would defeat one object of the exercise, which is to provide regular supervision of persons 'at risk' in the community."

Miss B. Tinnion, relief nurse, has also contributed the following comment on the same survey:—

"These visits were done during the month in which the patients reached their 75th birthday.

I found that the majority of patients were maintaining their independence and doing their own housework and shopping. The latter however was frequently done from mobile shops which made it more expensive. Families are on the whole very good in helping with washing and heavy work such as spring cleaning.

One noticable point for criticism was the lack of fresh fruit, vegetables and meat in their diet."

Miss M. Butler, health visitor, has also commented on an over 75 year survey in Longtown:—

"An over 75 year survey in Longtown was started in May, 1969. Firstly, a collection of names of every person over 65 years was taken from both general practices. These were then divided into two groups—65 to 75 years, and 75

years plus. Each person was given a card and details of relevant information recorded. Part of this information was had from the general practitioner who personally checked each card over a period of a few weeks. The over 75 year group was again sub-divided into—those living alone, handicapped, or thought to be at risk in any way. This group was visited first, and eight months later we are still systematically visiting every person on the list. Once visited, we assessed the need for a weekly, monthly or three-monthly visit. The follow-up work slowed our progress considerably.

This was quite a project and since we are only half way it is too early to give any statistics. The general impression so far, was that this was a fairly active and healthy group—perhaps because before, my visiting had been confined to those at risk or in need, or again those directly referred by the general practitioner. In spite of this it has revealed need, loneliness, poverty, malnutrition and sheer inability to cope.

One of its greatest uses in the months ahead might be a ready made and well known calling list for geriatric screening clinics:"

Table of Visits	**1969**	**1968**	**1967**
Visits to babies and children under 5	44,836	49,801	53,058
Visits to patients with mental disease	885	784	550
Visits to other age group	5,829	4,148	2,670
Visits to patients over 65	17,925	17,001	14,519

Apart from the effects of a falling birthrate, visits to the under five's are becoming more selective. As one would expect visits to other age groups are increasing rapidly as health visitors become more and more involved in the practice populations, and are asked to use their skills of medical and social assessment and to make the necessary referrals either to the general practitioner or other social or voluntary agencies.

Mrs. A. Donald has provided a final general comment on the service offered by the health visitor:—

"It is now over a hundred years since a system of health visiting was introduced in Britain. The work was first done by 'respectable working women' who visited in prescribed areas. As time went by, various Acts of Parliament relating to health and social welfare were passed and the need for health visitors was realised; so trained nurses with experience in social and welfare work were employed by local authorities. These women still worked in prescribed areas in the towns and cities, the centre for their work was in Child Welfare and School Clinic. Some of these health visitors had little contact with the general practitioners and it may be because of this, that the latter failed to understand the nature of the work or the aims of the health visitors. In some instances the general practitioners regarded the health visitors as "those interfering women in green"! In the rural areas the health visitor combined her work with home nursing and midwifery and her relationship with the family doctor was usually good.

This system worked fairly well but increased co-operation between doctors and local authority was needed—it was realised that the nurses and health visitors could do much to relieve the doctors of some of their work and so attachment of local authority staff to general practices was started. For some health visitors this was an unhappy time—they were on the whole willing to work with doctors but some doctors were still uncertain about the health visitor's work and aims. Gradually each began to understand the other and at the present moment the relationship between health visitor and general practitioner is in most cases very good.

The work has gradually changed although the health visitor is still responsible for child welfare, supervision of the elderly, educationally subnormal, handicapped, and home helps. Child welfare centres are held in some surgeries and some of us hope that we will be able to have developmental examinations done by the doctors instead of by the local authority medical officers. Immunisation is now done by health visitors instead of by doctors and medical officers.

It seems obvious that in some practices where the health visitor is given a large number of old people to visit that help will be required by the appointment of geriatric visitors just as the district nurses will need help from bath attendants.

But there is more change in domiciliary work to come. During 1970 we shall know if the Government is ready to accept the Maud Report and Green Paper".

Health Education

Health education is the imparting of positive knowledge about the maintenance of good health to various groups of people.

There are two methods of "Health Education". The more commonly used approach is the person-to-person contact when the nursing personnel visit patients in their own homes or see them individually at doctors' surgeries or health clinics. Because of the nurses' knowledge of the families and their homes such health teaching can be directed towards the personal needs of that family, and often teaching is done in such a way that the family does not realise how much has been taught.

The second Health Education method is that of giving formal talks or leading discussions with groups of people—from perhaps five or six mothers in a surgery or clinic to a class of 40 or so children in school. Obviously such sessions must be taken by a nurse with a particular aptitude and liking for teaching, and all health visitors have teaching training. Seven hundred and fifty-six such formal sessions were held during 1969 in the county on subjects varying from antenatal preparation to home safety, weight reduction and home nursing. In addition lectures were given by senior staff to various professional organisations. A regular session is held in every Police Constables' Course on "Emergency Midwifery". It is a possibility that in an emergency the rural policeman may have to deliver a baby.

Inspector Simpson, from the Police Training School, writes:—

"During the year under review members of the Health Department gave talks on midwifery to officers of the Cumbria Constabularly attending refresher courses at the Police Training School, at Halfway House, Bridge Lane, Penrith.

A total of 97 officers attended ten courses which took place during the year and much appreciation has been expressed regarding the value of these talks to operational police officers."

The nursing officers frequently speak to student nurses in hospital on the organisation of the County Health and Welfare Service.

An interesting and expected development is the increase in Health Education sessions being held in doctors' surgeries. Obesity clinics have started in group practice premises in various areas and sessions are also held there on various health topics. The type of teaching which can be given in surgeries is obviously limited by the type of accommodation available, but it is hoped that such health education sessions in surgeries will continue to increase and develop to cover the varying needs of the patients in each practice.

Posters and leaflets are used to display particular aspects, and I mention particularly the campaign against Smoking.

Total sessions during the year 1969 are as follows:—

Schools	249
Clinics	50
Ante-natal classes	366
Mothers Clubs	43
Other Organisations ...	28
Surgeries	20
Total sessions	756
Total Attendances	10,839

At the end of 1969 a survey was made of the Health Education methods and equipment used throughout the County, and all Health Visiting personnel involved in teaching were interviewed. As a result of this survey the organisation of Health Education throughout the County will be streamlined and equipment more easily obtained by the nurses for their teaching sessions. Plans have been made to teach Health Visiting staff how to handle the 16 mm. sound/movie projectors which are available in each Area. Other plans include training in the teaching of psychoprophylaxis (ante-natal classes) to those Health Visitors and midwives who are interested and have not already been trained.

Miss E. Tongue, health visitor, writes:—

"A very worthwhile part of health education is the holding of 'Preparation for Childbirth' classes at the County Clinic in Brampton. These include the teaching of the psychoprophylactic method of childbirth and parentcraft. Each session lasts for eight weeks and new sessions begin on the first Monday of alternate months. There is usually an average of six mothers per class—a good number for discussions and for the size of the room. Larger classes present problems with equipment and space.

Teaching is informal: mothers are advised to buy literature and books dealing with childbirth and I encourage informal discussion although there is also a place for formal teaching.

I also arrange a hospital visit. This is invaluable for those going into the Cottage Hospital for the first time.

Towards the end of a session I like to have one or two newly delivered mothers attend a class so that they can tell their impressions of labour and answer questions. I find this is a very valuable exercise and a help to myself as well as the expectant mothers. They usually bring their babies along with them and this leads to discussions on finding a daily routine.

The following quotations are from mothers who have attended the classes:—

'The general discipline of doing the exercises and learning about one's own body is a good thing.'

'The breathing exercises are a definite help towards relaxation. I feel that having used the breathing during the first stage of labour I was more relaxed and less tired than I might otherwise have been and therefore more able to manage the second stage more effectively and efficiently.'

'The hospital staff and general practitioners all agree that these classes help mothers in labour and the staff can easily pick out the mothers who have attended the classes. One general practitioner stated the classes are well worthwhile especially for primiparous women."

HOME HELP SERVICE

Section 29 of the National Health Service Act, 1946

"A local health authority may make such arrangements as the Minister may approve for providing domestic help for households where such help is required owing to the prescence of any person who is ill, lying-in, an expectant mother ....., aged, or a child not over compulsory school age, within the meaning of the Education Act, 1944".

HOME HELP SERVICE

It is only recently that the provision of a Home Help Service has become a statutory duty of the local authority under Section 13 of the Health Services and Public Health Act 1968, although a satisfactory service has been run by this and most authorities for many years.

The home help may be regarded almost as a basic social welfare worker and certainly she is much more than a domestic worker. She is the member of the community health team who spends more time in the patient's home than anyone else—she is often the one who listens to the patient's problems and channels them to the appropriate person—health visitor, nurse or social worker as the case may be. One could say that the home help has a true nobility of purpose, particularly as nearly all these workers perform extra tasks for their patients in their off duty hours. Some take their patient's washing home to do, others will take messages or do the shopping on their way to their patients. When their elderly patients are removed to hospital either temporarily or permanently their home help is not infrequently their most regular visitor.

As in previous years the number of households assisted by the County Council's Home Help Service has risen. This year the total number of families helped was 1,462—an increase of 116 on the previous year. By far the greatest proportion of people assisted, 84%, are elderly people, who with the help of this service and other community services as necessary, are able to remain in their own homes living independent lives. Without this service many would have had to go into institutional care.

The histogram printed on page 85 shows the totals and the proportion of types of cases helped. This remains the same as last year, with maternity cases accounting for only a very small part of this service.

Where necessary, resident home helps are provided in cases of particular need. A plan for providing "intensive community care" for elderly patients discharged from hospital is being discussed and, it is hoped, will be implemented early in 1970. This

scheme will aim to provide up to 24-hour care, and will be mainly for those patients waiting for a place in an old people's home, who are well enough to be discharged from hospital but not well enough to live alone except with maximum support.

This intensive community care will, it is thought, be particularly necessary should an influenza epidemic affect Cumberland and cause increased pressure on hospital beds. To this end, meetings are being held with area medical, nursing and social welfare officers to ensure that such care will be available.

Care is taken to select the right home help for any special need. One particular case springs to mind during the year: a child was prescribed a special diet which the mother found difficult to prepare. A home help was assigned to this case to assist the mother, and successfully taught her how to plan, cook and prepare this diet.

The vans provided in each area are invaluable, particularly in the case of patients living in remote fellside cottages and farmhouses where public transport is infrequent or non-existent and where, without the vans, a home help could not reach them. It is possible, by using these vans, to carry modern equipment for use where necessary.

The following table indicates how the work of the Home Help Service was divided between the three areas.

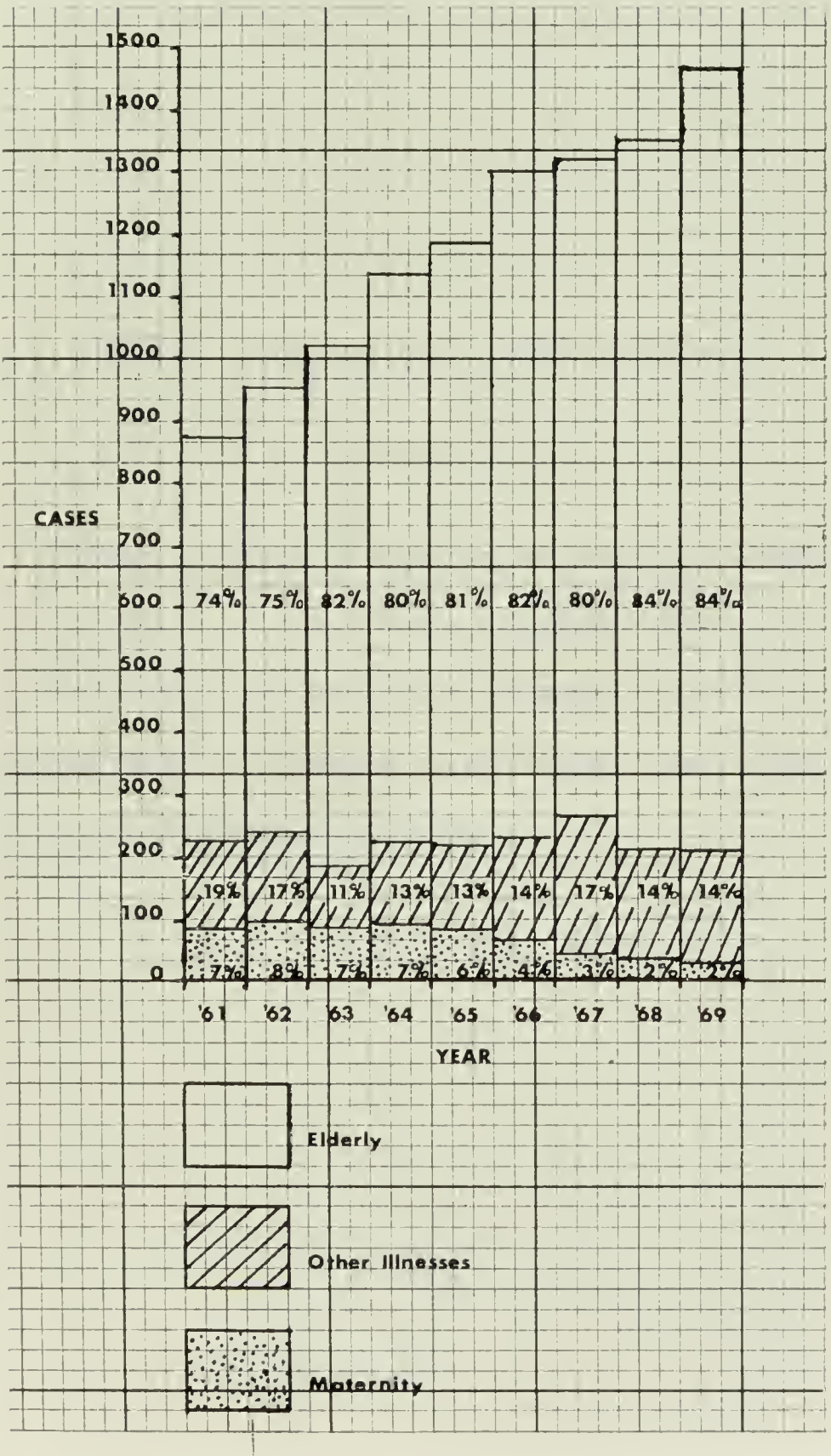
Area	No. of households assisted	No. of Home Helps
Northern	415	106
Southern	481	74
Western	566	86

As the above table shows, the Northern Area with the largest number of home helps, in fact assisted the least number of families. This may be attributed to the extremely rural stretches of the Northern Area, with its large acreage of fell and moorland. In the more populated areas of the West and South one home help may be able to visit several families, but this is not often possible in the North where the home help has much travelling to do.

Requests for help in the home come from patients, general practitioners, health visitors, home nurses and hospital staff. Previously the area nursing officer visited those who required the services of a home help to assess the need: these interviews are now carried out by the health visitor and home nurse.

It is thought that under the new Social Services Bill the Home Help Service will become part of the Department of Social Services.

HOME HELP CASES



CARE OF MOTHERS AND YOUNG CHILDREN

Section 22 of the National Health Service Act, 1946

"It shall be the duty of every local health authority to make arrangements for the care, including in particular dental care, of expectant and nursing mothers and of children who have not attained the age of five years and are not attending primary schools maintained by a local education authority."

CARE OF MOTHERS AND YOUNG CHILDREN

Amongst the various services which are gathered together in my annual report under this heading one stands out this year in terms of significant development. This is the dental service which reached an important landmark in the commencement of the introduction of 1 p.p.m. of fluoride into the water supply from Crummock. Dental caries ranks high on the morbidity table for children today and this new development will provide a major contribution to child health in the years ahead. I look forward keenly to the extension of this scheme during 1970.

Another service dealt with in this section of the report is the provision of play groups for pre-school children and I am glad to report an increasingly active involvement of the department in the extension of this work which is carried out on a voluntary and private basis. Nurseries or child-minders are registered by the county council to ensure suitable circumstances and standards for the carrying out of this work: work which in my view contributes very significantly to child health and development, both for normal and for handicapped children.

The unsupported Mother and her Child

The care of the unsupported (usually unmarried) mother and her child has long been accepted as a joint responsibility of the Diocesan Moral Welfare Association and Local Authority Health and Welfare Departments. Field work was mainly the province of the voluntary organisation and the local authority assisted mainly by financial contribution of one kind or another. Changing social attitudes to this subject, however, inevitably bring in their train a need to re-think the patterns of service to these mothers and their children and I am greatly encouraged by the very enlightened attitude which so many voluntary organisations connected with this work are taking; organisations which in the past have provided a fine service when no one else was able or willing to do so. Now major changes in the whole pattern of development of social work services in the community are upon us and one of the features of these changes will be a more comprehensive approach by the new Local Authority Social Service Departments to groups in the community requiring social advice and support; an approach based in the supply of trained social work skills on a scale which will

ultimately embrace much of the work at present carried out by voluntary organisations in certain fields. This is all very much in line with the thinking of the Seebohm Committee which gave rise to the present Local Authority Social Services Bill which is before Parliament.

But there are always new fields to be explored by vigorous and active organisations such as the Diocesan Moral Welfare Associations. And I am very glad to see that this challenge is being accepted in the field of provision of hostel accommodation for unmarried mothers and their babies in certain cases. Miss Pochin deals with this in her report which I quote again below and for which I am greatly indebted to her.

The table below shows the illegitimacy rate for Cumberland and England and Wales from 1964-1969:—

	Administrative County Rate per 100 total live births	**England and Wales** Rate per 100 total live births
1964	4.7	7.8
1965	5.6	7.7.
1966	5.8	7.9
1967	6.6	8.4
1968	6.0	8.5
1969	6.6	8.4

The consistently lower figure for the county than for England and Wales is shown.

Mortality rates for illegitimate children are consistently higher than for legitimate children and I show below the table of Infant Mortality rates for both Cumberland and England and Wales:—

	Infant death rate			
Year	**Cumberland Legitimate**	**England and Wales**	**Cumberland Illegitimate**	**England and Wales**
1964	18.5	19.4	15.3	26.3
1965	16.5	18.5	22.6	24.9
1966	21.1	18.5	18.6	24.5
1967	16.0	17.9	29.7	23.7
1968	18.5	17.8	29.0	23.4
1969	18.2	17.4	26.8	25.4

The high Cumberland figure over the past three years is rather disturbing especially since previously we have maintained a lower figure than that for England and Wales. It is true that the total figures involved are not large but I am going into this subject in greater detail at present.

The next table shows the numbers of unmarried mothers for whom the County Council accepted supporting financial responsibility in a mother and baby home. The percentage in brackets after each total indicates the proportion of all illegitimate births in that year for which the County Council accepted financial responsibility in a Mother and Baby home.

	1965	1966	1967	1968	1969	Total
15 years	1	—	1	—	—	2
16 years	6	3	2	2	2	15
17 years	6	10	2	1	7	26
18 years	13	5	4	4	2	28
19-24 years	31	18	13	15	13	90
25-30 years	2	4	1	2	2	11
31 years & over	1	2	1	1	—	5
TOTAL	60 (22.1)	42 (19.5)	24 (10.1)	25 (12.1)	26 (13.0)	177

It will be seen that the figure for Cumberland admissions to Mother and Baby Homes has tended to 'flatten out' in the past three years. The main reduction has probably now taken place and less marked changes may be seen in the years immediately ahead. It would seem that the Cumberland trend of recent years is now being followed by other local authority areas since the total number of admissions to Coledale Hall as shown in Miss Pochin's report is substantially reduced.

Miss J. C. Pochin, Organising Secretary for the Carlisle Diocesan Council for Social Work, writes as follows:—

> "Church Social Workers, not only in Cumberland but throughout the country, had fewer pregnant girls referred to them last year. This downward trend is reflected in the

usage of Mother and Baby Homes everywhere. There were 45 admissions at Coledale Hall last year, compared with 54 in 1968, but the average length of stay of the clients increased from 57 days to 70 days. Miss Wilson found that the girls who came to her had more difficult problems: inadequate personalities, family tensions and emotional upheavals were common, but in addition several girls overstayed their time very considerably for the sole reason that they had nowhere else to go.

Perhaps as a result of growing up in a tolerant and affluent society, young adults are showing a new spirit of independence. Whereas, until quite recently, an unmarried mother who had no home for her child and no means of supporting him would feel compelled to offer him for adoption, nowadays she may insist on keeping her baby. Too often the mother and child are pushed around from living-in job to digs, to friends, to house of doubtful repute, until after a year or so the embittered young mother has to admit failure and her baby is received into the care of the Children's Department.

In order to lessen the risk of this situation the Carlisle Diocesan Council for Social Work is at present investigating the best means of providing flatlets for the more capable unsupported mothers, and a hostel with nursery accommodation, with very flexible terms of reference, for those who need more help.

It is too early yet to make accurate statements about the effect of the Abortion Act. Very often the demand for abortion is a panic reaction in the early stages of pregnancy. If the request is refused, the caseworker has a doubly difficult task to reconcile her client to the prospect of the coming baby; yet it has been found that the child is quite likely to be kept and cherished in the end."

Welfare Foods

It is a statutory duty of the Local Authority to distribute welfare foods on behalf of the Department of Health and Social Security.

The decision as to whether proprietary foods also are sold at child health centres has been a matter for local decision, and this has in the past seemed the most logical channel of distribution for both proprietary foods and National dried milk, orange juice and vitamin extracts.

The child health centre today, however, is developing a more professional image. Nutrition is no longer presenting the sort of problem it has in the past and stress is now being placed upon developmental supervision, on prophylaxis, health education and on the psychological and social problems of the family. The child health centre of the future as envisaged in the report of the Sub-Committee on Child Welfare Centres will concentrate "on the maintenance of the health of infants and young children detecting at an early stage the presence of handicaps and departures from normal health and giving advice and counselling to parents on the manifold problems which may arise during the raising of the family". In keeping with this recommendation the selling of proprietary welfare foods in child health centres has been gradually phased out in Cumberland during the past year, and the process will be completed by 31st March, 1970.

Area Medical Officers are responsible for the distribution of welfare foods. There are approximately 100 distribution points situated within the administrative county and include private traders and householders. Distribution is also carried out through the Women's Royal Voluntary Service which during the past year has in Cumberland once again proved to be an invaluable ally of the Department.

The following table gives a comparison of the sales of welfare foods over the past ten years.

Year	National Dried Milk (Tins)	Cod Liver Oil (Bottles)	Vitamin Tablets (Packets)	Orange Juice (Bottles)
1960	92,676	14,961	7,475	90,343
1961	78,155	9,067	5,017	50,653
1962	79,446	4,712	2,669	31,964
1963	78,858	5,162	2,630	34,943
1964	74,886	4,909	2,236	36,389
1965	78,047	4,636	1,881	39,053
1966	74,902	4,326	1,771	41,636
1967	69,460	4,131	1,405	43,459
1968	67,116	3,844	1,138	42,705
1969	50,851	3,531	1,176	46,198

Report on the Dental Service for 1969

From the point of view of child welfare patients 1969 has proved to be a most memorable year, because fluoridation of water was introduced into the West Cumberland supply in September. Considering that this is the greatest advance in the prevention of caries that has ever occurred, one is proud to announce that almost one third of the population in the County is now receiving fluoridated water.

In September a Dental Auxiliary started work in South and West Cumberland, and very soon she proved to be a great asset in the treatment and education in health matters of the young child. The attitude of an auxiliary to young children is very different from that of a dental officer, because of the age differential and also because a young girl has a different phychological approach. Whether or not some form of maternal instinct enters into the question is debatable, but these girls certainly have a wonderful technique and do very good fillings.

It is now becoming more and more evident that in all future building programmes twin surgery suites must be provided so that auxiliaries can be used more universally. There is no doubt that a better and more adequate service can be provided in rather larger units where X-ray facilities and hot air sterilisation are a more viable proposition.

The number of maternity patients requesting treatment still remains very small. One can, however, readily appreciate the fact that few people would change their dentist for the short time for which they would benefit, but it is a great pity that more pre-school children do not take advantage of the services offered by the clinic. In future it is to be hoped that more mothers will be made aware of the advantages of early treatment for their children when the auxiliaries have given dental health education talks to them when they attend baby clinics.

Fluoridation of Water Supplies

It has, for a variety of reasons, taken six years to implement the County Council's decision that the fluoride content of the public water supplies in the county should be adjusted to the

optimum level of one part per million. However, I am pleased to report that fluoridation has been introduced into two sources of supply during 1969.

The first to begin covered only a very small part of the county—two parishes in the Border rural district getting their water from the South West Northumberland supply provided by the Newcastle and Gateshead Water Company. Adjustment of the fluoride content began there on 21st April, 1969, and regular sampling at Gilsland since then has shown that the level has been maintained between 0.9 and 1.05 parts per million, which are within the permissible limits.

On 8th September, 1969, the addition of Sodium Silico Fluoride began at the biggest source of supply in the county in terms of population served. It is the Crummock Water source and, although agreement to fluoridate this water was reached with West Cumberland Water Board some years ago, it has had to await the provision of new treatment works to cope with the output of about 3,000,000 gallons of potable water a day. The population of about 62,000 which is served live in the Cockermouth/Maryport /Workington areas.

The West Cumberland Water Board has also agreed to the fluoridation of its other main sources of supply—Quarry Hill and Hause Gill—but firm dates for the work have still to be settled.

The South Cumberland Water Board has agreed in principle to the fluoridation of its Ennerdale Lake and Baystone Bank sources. The former is by far the bigger supply, serving 45,000 population, and now that work connected with the raising of the level of the lake is going ahead preliminary consultations about fluoridation have begun. It is hoped that the County Council and the Water Board will have approved detailed proposals and concluded the necessary agreements to enable work to begin and fluoridation to begin, in 1971. It is also hoped that the Baystone Bank supply can follow quickly—the district council served from there is certainly anxious that it should.

The county area around Carlisle which is served by the Carlisle Water Board has a population of around 30,000, mostly getting their water from two sources. After some doubt as to whether

those supplies would be fluoridated within the foreseeable future it has recently been decided to make financial provision for the necessary installation work to begin in 1971.

The remaining water board in the county—Eden Water Board—has, unfortunately I believe, decided to take no further action on fluoridation. The situation there is complicated by the fact that the Board serves two authorities, Cumberland and Westmorland, and the latter has steadfastly held the opposite view to Cumberland County Council's on this question.

To be able to show, in years to come, that fluoridation has in fact brought the benefits which its supporters claimed for it will require facts and figures. To provide a base line for this information Professor P. Jackson, Professor of Children's and Preventive Dentistry at Leeds University, arranged for Mr. J. F. Gravely of his staff to examine 100 children in each of the age groups 5 and 15 years of age in West Cumberland before fluoridation began. As a control, a similar number of children in the same age groups were examined in another area. There will be follow-up examinations in 5 and 10 years' time.

Despite the delays in pushing forward with this most desirable preventive measure of fluoridation I am optimistic that at least two-thirds of the county's population will have the benefits available in the next two years.

Child Health Centres

During 1969 it has become increasingly evident that more sensible use is being made of the child health centres. Mothers no longer regard the clinic just as a place for buying cheap baby foods and having their babies weighed, but as a place where they can see their health visitor and doctor for advice and help. In several county clinics general practitioners hold their own child health sessions, other general practitioners have child health sessions in their own surgeries. To a large extent this is dependant upon the surgery accommodation available.

The trend is now towards less frequent but more purposeful visits by mothers to clinics, whether held at general practitioners' surgeries or in county premises.

An interesting development during 1969 has been the cessation of the sale of proprietary baby foods in the clinics. This has relieved the health visitors of a good deal of clerical work and has helped considerably to give the clinic its rightful status—that of a centre for advice and help and not a cut price shop.

Weighing of babies is also less frequent now. Babies are much more frequently overweight than underweight and a great deal of time is spent by the health visitors in explaining sensible feeding to avoid the problem of the fat baby who becomes a fat child and then an overweight adult.

Vaccination and immunisation sessions are now programmed by computer in the Southern Area, and more and more of these sessions are being carried out in the general practitioners' surgeries by the family health care teams rather than in the county clinics. This has helped to avoid duplication of visits and provided a unified service for the mother and her child.

Miss R. Sheppard, Health Visitor, writes:—

"I have been holding a Well Baby Clinic in the General Practitioner's surgery since 19th March, 1969: the session is weekly for two hours, general practitioners referring babies or children for follow-up as required. Up to the present, a general practitioner has not been available owing to pressure of work.

For the future, the session will continue but for the first hour a surgery will be held when children may be seen by the doctor. Any purely nursing procedures — hearing tests, routine checks, general advice and/or discussion will be held during the last hour. Vaccination and immunisation will also be undertaken at this clinic; at present this is done on another day in conjunction with the ante and post-natal clinic.

We are hopeful that the new arrangement, by providing a more comprehensive service, will be of benefit to mothers and children in this practice."

I would like to express my sincere thanks to all the voluntary helpers in the clinics who give very real help to my staff in re-

lieving them of non-nursing duties, and who do so much to retain the informal and friendly atmosphere in the clinics.

The very large clinic is discouraged because it is impossible for a health visitor to give good advice and care to everyone if more than 30 or so mothers attend.

Miss M. Butler, Health Visitor, writes:—

> "Longtown Clinic is not a health centre as we understaod the meaning of the word, but to the people of Longtown it is just that since it has become the most obvious place of **contact** between themselves and the various health services available. They actually see their own doctor working alongside the nurse and health visitor, taking the many preventive measures in their interest. It is regarded and spoken of as **our** clinic and a great deal of pride is taken in its appearance, even though we find it hard to keep the shine on the floor since it is so well used by so many feet. It has been open about $1\frac{1}{2}$ years and most months see a new addition to the programme, or a change to meet new needs. As an instrument for health education its uses are limitless and continue to grow—it is very far from reaching its full potential."

The child health clinic of the future has many interesting possibilities in the context of the evolution of child health services generally. The increasing interest of general practitioners in this work is a vital factor in the development and the emergence in group practices of a partner whose main interest is child health would go far towards securing the future of the service. This I see as a continum with the school health service, the whole increasingly coming under the aegis of the division of child health in the District General Hospital. From this 'nerve centre' of child health services a variety of workers will operate offering specialised screening and supervisory services to group practices for both normal and handicapped children. I envisage both the clinical and the community paediatrician working together from such a centre (which would also fulfil the function of an assessment centre) and attracting into the division or department general practioner paediatricians from group practices for on going training and coordinaton of services for children inside and out of hospitals. The

present medical officers in local authority health departments will have a key role to play in this developing situation; one in which they will base full opportunity to deploy their special skills in the assessment and supervision of handicapped children.

Meantime I am glad to see increasing interest amongst some general practitioners in short in-service training courses in child health matters being provided at Newcastle: and in 1969 two general practitioners attended one such week-end course with financial support from the County Council.

Attendances at Local Authority Child Health Centres 1960-1969

Year		No. of centres provided at end of year	No. of child welfare sessions held per month at centre	No. of children attending during the year and who were aged			Total No. of children who attended during the year	Total attendances during the year
				Under 1 year	1 - 2 years	2 - 5 years		
1960	...	22	95	1548	1408	1368	4324	22089
1961	...	23	95	1603	1667	1704	4974	23004
1962	...	27	96	1894	1625	2080	5599	27299
1963	...	29	98	1901	1892	2007	5800	31948
1964	...	30	106	2231	1865	2145	6241	35162
1965	...	31	110	2322	2385	2285	6992	36852
1966	...	33	119	2193	2185	2213	6591	33521
1967	...	33	117	2080	1859	1890	5829	32420
1968	...	32	131	3086	1450	1728	6264	31326
1969	...	29	134	1927	1812	1697	5436	31018

CHILD HEALTH CENTRES, 1969

The following table gives particulars of the sessions and attendances at Child Health Centres throughout the County:—

Centre	Address	Day	No. of Sessions	Total Att.	Average Att.
Northern Area					
Alston	Cottage Hospital, Alston	Wednesday	50	495	10
Anthorn	W.V.S. Welfare Office, Anthorn	2nd and 4th Thursday	5	23	5
Aspatria	North Road, Aspatria	Wednesday	49	767	16
Brampton	Union Lane, Brampton	Friday	52	1,594	31
Dalston	Village Hall, Dalston	1st and 3rd Monday	22	445	20
Houghton	Village Hall, Houghton	2nd and 4th Wednesday	23	381	16
Hunsonby	The Institute, Hunsonby	1st and 3rd Thursday	16	300	19
Longtown	Burn Street, Longtown	Tuesday	53	1,277	24
Nenthead	Doctor's Surgery	1st Tuesday	12	66	5
Penrith	Brunswick Square, Penrith	Tuesday	49	1,939	40
Scotby	Village Hall, Scotby	1st and 3rd Thursday	22	350	16
Thursby	Church Hall, Thursby	2nd and 4th Monday	23	230	10
Wetheral	Village Hall, Wetheral	2nd and 4th Thursday	23	262	11
Wigton	Birdcage Walk, Wigton	Monday	49	1,026	21
			448	9,155	20

Centre	Address	Day	No. of Sessions	Total Att.	Average Att.
Western Area					
Broughton	Nurse's House	3rd Wednesday	23	204	9
Cockermouth	Harford House, Cockermouth	Monday	48	1,002	21
Dearham	Nurse's House, Central Rd, Dearham	4th Wednesday	11	111	10
Keswick	13-15 Bank Street, Keswick	Thursday	51	749	15
Maryport	24 Selby Terrace, Maryport	2nd and 4th Tuesday	76	3,179	42
Seaton	Miners' Welfare Hall, Seaton	2nd and 4th Thursday	27	653	24
WORKINGTON—					
Park Lane	Park Lane, Workington	Wednesday and alternate Thursday	107	2,322	21
Salterbeck	Holden Road, Salterbeck, Workington	Friday	46	634	14
			389	8,854	23

Centre	Address	Day	No of Sessions	Total Att.	Average Att.
Southern Area					
Cleator Moor	Ennerdale Road, Cleator Moor	Thursday	47	204	16
Egremont	St. Bridget's Lane, Egremont	Tuesday and Thursday	52	1,501	29
Millom	18 St. George's Road, Millom	Tuesday	48	1,364	29
Seascale	Gosforth Road, Seascale	Thursday	558	5,455	10
Thornhill	Community Centre, Thornhill	1st and 3rd Wednesday	21	247	12
WHITEHAVEN—					
Flatt Walks	Flatt Walks, Whitehaven	Monday and Tuesday	49	1,432	29
Mirehouse	Dent Road, Mirehouse, Whitehaven	Monday	50	1,626	32
Woodhouse	Woodhouse, Whitehaven	Wednesday	49	1,180	24
			874	13,009	15
		GRAND TOTALS	1,711	31,018	18

Family Planning

Once again, because of financial restrictions, the authority has been unable to implement its policy to use the Family Planning Association as agents in the provision of a family planning service throughout the county. However, a memorandum prepared by the County Councils' Association and the Association of Municipal Corporations, in conjunction with the Family Planning Association, was considered. It gave guidance to local authorities and set out the various methods by which a family planning service could be introduced with comment on some of the problems which could arise. As a result, the authority decided that action to provide a family planning service through the agency of the Family Planning Association should definitely be taken in the financial year 1970/71 and budget provision was made for a grant of £1,000 to the general funds of the Family Planning Association.

Meanwhile the authority continues its assistance to the Family Planning Association by making available clinic accommodation and equipment free of charge at Millom, Penrith, Whitehaven and Workington, while at Alston and Keswick accommodation has been provided at the local hospitals. In Carlisle the Borough Council made accommodation available in their new clinic and allowed the attendance of county residents from the surrounding area.

During the course of the year there was also discussion with the Family Planning Association on The Poisons (No. 2) Rules 1968. Under these regulations the County Council is legally responsible for the safekeeping of all drugs which are stored on local authority premises and the discussions covered the precautions which would need to be taken where the Family Planning Association use such premises for their clinics. Full agreement was reached and subsequently the staff at family planning clinics were given detailed instructions on prescriptions and the labelling and storage of oral contraceptives. A specified person in each clinic is responsible for storage and the arrangements have to be inspected by a doctor at least every three months. The clinic doctors appointed by the Family Planning Association were approved by the County Council as responsible for these inspections.

Mr. S. Camm, Secretary to the Lakeland Branch of the Family Planning Association, on the Executive Committee on which I am a co-opted member, writes:—

"One of the most important events of the year was the indictment of the high risk pills which were promptly removed from the Family Planning Association approved lst, and leaflets 'Change to the Lower Risk Pill' printed for general distribution.

The Government are now making a grant of £20,000 p.a. for five years to further training in family planning.

The I.T.V. have removed the ban on advertising family planning on television and the B.B.C. have commenced to put out sex information to children on both radio and television.

Vasectomy, which was an experiment at our Cardiff Clinic has proved so popular that many other clinics are being opened throughout the country. Preliminary enquiries are being made in this branch for such a clinic.

Four doctors have been trained for work in our clinics and two are under training at the present time. Seven nurses have been trained and two are under training.

A Speakers' Training Course was held in Manchester during October, 1969, which resulted in the branch now having four Family Planning Association accredited speakers.

I.U.D. sessions are now being held at Carlisle Clinic. It is noted yet again that the referrals from hospitals and local authorities are extremely low compared with other areas.

The National Council have decided that patients' fees shall be increased from 1st April, 1970. This will cause a lot of consternation in the poorer areas of the branch and local authorities could assist us a great deal by subsidising their 'Medical' cases, and where necessary their 'Socially necessitous'. The Family Planning Association remit fees and the cost of supplies in 'needy' cases which are brought to notice".

Mrs. Lyne, Secretary of the West Cumberland clinics, writes:-

"The Family Planning Association clinics at Workington and Whitehaven are held on Wednesday evenings in local authority premises. 1st, 3rd and 5th Wednesday at Workington, 2nd and 4th at Whitehaven. Co-existence is facilitated by friendly co-operation on the part of the day staffs. Our staffing consists of one doctor and one nurse with three lay-workers at Workington, where a postal service is carried out, and two lay-workers at Whitehaven. Regularly a double doctor session is held at either clinic when numbers warrant it. We operate an appointments system but no patient, or would-be patient, is ever refused help.

A study of statistics has shown no marked swing towards any one method of contraception, although an increase in the number of requests for I.U.D. is apparent since this service became available in Keswick. The switch to low dosage pills was carried out with commendable sanity by our patients, supplemented by a great deal of extra work from lay-workers who are, without exception, voluntary.

Recently it has been noticed, with pleasure, that many husbands and fiances are attending sessions with their partners. More 'families' are reaching the Family Planning Association and, in West Cumberland, we hope for a fuller implementation of the Family Planning Act of 1967 as soon as circumstances allow, so that we may reach more families".

An interpretation of the statistics for the Lakeland Branch of the Family Planning Association indicate, for the area as a whole, an increase of 20% in the number of women attending the clinics. Almost all this increase was in the group of women taking family planning advice before their first pregnancy and other groups showed ltle change.

Pre-School Playgroups

The local health authorities are required under the Nurseries Child Minders' Regulation Act, 1948, as amended by the 1968 Act to keep registers of

(a) premises in their area, other than premises wholly or mainly used as private dwellings where children are received to be looked after for the day, or for a part or parts thereof, of a duration or an aggregate duration of two hours or longer, or for any longer period not exceeding six days;

(b) of persons in their area who for reward receive into their homes children under the age of five to be looked after for the day, or for a part or parts thereof of a duration or an aggregate duration of two hours or longer or for any longer period not exceeding six days.

In the case of (a) the registration is of the premises as a 'nursery'; and in (b) the registration is of the person responsible for a group as a 'child minder'.

The year 1969 has seen an emphasis on the importance of Nurseries and Play Groups. New legislation has come into effect necessitating the re-registration of all such organisations and the medical supervision of those who work in them. In the era of the small family it is often the mother who is tied to the children's apron strings and in many cases the prime importance of the nursery is to give the mother a relative freedom which she previously did not have, a benefit which shows itself in her own improved well-being and that of her family.

The other principal function of such groups is their contribution to the smooth emotional and social development of the young children who mingle in the increasingly wide range of activities provided. These aspects of the subject are very helpfully dealt with below by two widely experienced organisers of groups in Cumberland to whom I am grateful for their comments.

Were these the only advantages, the nursery would be filling an increasing social need, but the nursery, or play group, has another important role in helping children in special need because of their own handicaps. A child's health and welfare can be affected simply through lack of other children of like age with whom to play. Similarly, mentally or physically handicapped children may suffer social isolation purely as a result of their

handicap. For such children the nursery can provide a social background at an early age which must obviously enormously advance their later opportunities of living an active life within the community. Indeed this can be considered as one of the first steps in the modern concept of community care.

Where financial need exists it is now possible for the local authority to assist the parents of such children, and the nurseries have all agreed wherever possible to accept such children. In addition, towards the end of the year the County Council offered facilities at Orton Park for the Carlisle and District Association for the Mentally Handicapped to establish a playgroup for those subnormal children whose mothers stand more in need of occasional freedom than perhaps do any others.

For the future the great need is in educating mothers and other workers at such groups in modern aspects of child care and education. A promising start in this direction was made this year at Longtown by the Lochinvar College of Further Education who ran a well attended course in these subjects. It is hoped that further courses of this nature will be promoted during 1970.

During the year three new nurseries were opened in the Northern Area and three new Child Minders were registered.

In the Southern Area, the survey of pre-school playgroups has revealed on the whole quite a uniform distribution geographically and the number of places available is adequate for the immediate catchment area.

In the Western Area the number of places available has increased from 158 to 320.

This growth in the formation of pre-school playgroups has been encouraged by the County Council who have recently agreed to assist in the following ways:—

1. Increasing advisory help (including the establishment of training classes for organisers) and establishing contact with the infants' schools.
2. Encouraging the attendance of deprived or handicapped children and the promotion of groups where these children were in need.

3. Allowing the use of County Council premises (free of charge) for running suitable groups.
4. Affording limited help with equipment in appropriate cases.

Although there are no nurseries run by the Authority, at the end of the year there were 34 privately run nurseries registered for the care of 955 children.

The following table shows the location and places available in nurseries and child minder groups throughout the county:—

Registered Nurseries

Northern Area		Southern Area		Western Area	
Abbeytown	20	Bootle	15	Cockermouth (3)	90
Alston	20	Cleator Moor	10	Keswick	40
Aspatria	30	Distington	30	Crosby	23
Brampton	30	Egremont	30	Portinscale	20
Cumwhinton	30	Frizington	20	Seaton	32
Dalston	20	Millom	30	Workington	115
Houghton	30	Seascale (3)	70		
Kirkbride	10	St. Bees	20	Total places available	320
Longtown	20	Whitehaven (4)	120		
Penrith	35				
Wigton	25	Total places available	325		
Warwick-on-Eden	20				
Total places available	290				

Registered Child Minders

Western Area		Southern Area		Northern Area	
Workington	10	Egremont	1	Brampton	20
		Millom (2)	2	Culgaith	2
		Seascale	10	Penrith (2)	7
		St. Bees	8		
		Whitehaven	1		

The number of places available in nurseries for children between the ages of $2\frac{1}{2}$ and 5 years in 1964 was 150 compared with 955 in 1969. The percentage of places available to the number of children eligible in this particular group has risen from approximately 1.5 in 1964 to 10.4 in 1969.

I am grateful to Mrs. J. Matthews, of the Brampton Playgroup for the following comments on play groups:—

"The establishment of playgroups has been growing very rapidly over the last two or three years. Almost every mother now wants her child to have the opportunity to attend a playgroup for several hours a week. Just what is she seeking for that child ?

Playgroups cater for children from the age of two and a half or three years up to the time of entry to full-time school. Playgroup experience gives the child a chance to play regularly with companions of his own age. Often by means of play the child can adjust to the outside world, to family situations, like the arrival of a new baby. He learns to trust adults other than his mother. For this to be successful the playgroup must have a nucleus of permanent staff.

Mothers often benefit too. Not only does the playgroup provide them with a few spare hours for relaxation or concentration on other things, but the contacts with other mothers and children, whether or not the mothers participate in the running of the playgroup, can be of great value in combatting the real loneliness often felt by mothers of very small children.

But a playgroup should provide more than all this. After nearly ten years of playgroup experience I see the playgroup as an instrument for the growth of the child's abilities. Dr. W. D. Wall, President of the Preschool Playgroups Association has said: "In the growth of the adult human being, 50% of the final ability is established in the years from birth to five years."

The real task of the playgroup is to give the child every chance to develop his latent abilities. These include social skills, including communication; physical skills, both on the

large scale needed in running and jumping and fine skills needed for writing and creative work; and imaginative, intellectual and perceptive skills.

In the successful playgroup the adults in charge must bear in mind the value of any of the child's activities in the process of developing all his abilities.

The responsibility for providing such a wide-ranging and stimulating atmosphere rest with the playgroup's supervisors. Intuition and experience may not be enough to provide the best. Training, formal or informal could always increase the supervisors' effectiveness.

It is encouraging to find that the demand for such training is growing along with the growth of playgroups, and that a start has been made wherever playgroups are established".

I would also like to thank Mr. K. S. Daniels for the following comments on the work of the nursery school at Workington:—

"The Nursery School at Workington is now in its third year; Whitehaven was started in March 1969. Both take children from $2\frac{1}{2}$ to 5 years. They can attend any number of sessions per week, from just one morning or afternoon up to 5 full days per week. Some stay to lunch. Both are independent schools charging session fees of 6/- per session. Both serve communities of about 30,000 people and are in or near the town centre.

It is always difficult to summarize aims in a few succinct sentences. I suppose that it is best put as an attempt to provide for the children of this age range an environment in which they can realise their full potential. This is a conscious effort, and involves deliberate thought about their social behaviour, their emotional needs, their physical development and their mental and educational guidance. The Nursery Schools try to be something more than a play group designed to mind children while parents are busy.

Apart from the training and education of the children, the Schools try as far as possible to help parents understand their

child's needs. This is a not unimportant part of the work and was recognised by Miss Alice Bacon, the Minister of State for Education and Science, when she opened a conference on "Home and School Relationships" in Birmingham recently. She said, "Nursery Schools provide an opportunity for a trained person to have an oversight of the young child, to recognise and advise if anything seems wrong, and to help the mother to understand the child's progress and development. Among other good side effects of nursery schooling is that a mother whose child has been to one of these classes will be the more ready to make and maintain contact with the school at five . . . and the parents' interest in their child's work has a profound significance for him".

This relationship between parent, child and nursery school is most important. Children of all ages take a great pride in their work, and are anxious to take home practically every piece of handwork, painting or craftwork that they do. They show Mummy everything, and take great comfort in her praise and approval. At Nursery School, constant contact is maintained with parents, and advice and suggestion is given where necessary. In a few cases with difficult, aggressive or antisocial children, or where it is felt that there is undue introspection or a marked lack of progress, parents may be referred for advice to Dr. Platt, the consultant paediatrician. Equally he has sent children to the Nursery Schools when he felt that this might prove beneficial to them.

Only a very few children of this age range are difficult or hostile. Most of the pupils are normal and healthy, full of bounce and vigour, and they welcome the variety of activities provided for them, whether it is making pastry, painting, dressing up, listening to stories and rhymes, caring for pets, or digging in sand, experimenting with water, or climbing about on the apparatus. Some learn to count or begin to comprehend the early concepts of number, the ideas of addition and subtraction. Others will be matching shapes and colours, a prereading exercise leading towards word recognition. The widening of experience leads towards a desire to record it on paper, and above all to find words to express it in speech. This in-

crease in vocabulary and in a child's command of spoken English is most marked and surprisingly rapid. It is a vital part of the work and one of the most rewarding.

The transition for a child at 5 years from an exclusively home life to a full life at School is often an overwhelming experience which can easily take a term or two to be totally accepted. There is a tendency, too, for the two different aspects of this life to be held distinct and separate in a child's mind. Instead of integrating the experiences of both, he tries to segregate them, and parents are well aware of the non-commital, even resentful, answer to their question, "What did you do at school, today?" At Nursery School age there is no such barrier, and the projecting forward of this relationship into their primary school is comparatively easy. Confirmation of this, and indeed of the ease with which pupils from Nursery Schools slip into Primary School routine, has been obtained from primary school headmistresses. The necessity of some give and take inside group behaviour will already have impinged ona child's mind; sharing, and working with other children, becomes semi-automatic. This is particularly marked in the children from the small family prevalent today, or in children from isolated families where the opportunities for communal play are limited. This preliminary social training and adaptation can save a child from the frustrations and tensons of abrupt entry to school at five.

At Nursery School, there is no hurry, and with the high staffing ratio of about 8 to one, no child is neglected. There is always a lap to sit on, a hand to hold when security is threatened, to be released again when re-assured or when the attraction of other activity entices."

Marriage Guidance Councils

Within the county there are two Marriage Guidance Councils, the Cumberland and Eden Valley Marriage Guidance Council and the Barrow and District Marriage Guidance Council. An annual grant is made by the County Council to these organisations and accommodation is made available in Park Lane Clinic, Workington, and in Brunswick Square Clinic, Penrith.

The Marriage Guidance Councils offer private counselling for people who have difficulties or anxieties in their marriages or other personal relationships. This work has been admirably pioneered by the Councils and is now a firmly established community service greatly appreciated by professional, medical and social workers. The latter are themselves involved as professional advisers to the Marriage Guidance Councils. Early in the development of this work, however, the Marriage Guidance Councils realised the need for a truly preventive approach to marital problems and took a lead in the promotion of youth counselling in secondary schools. This Educational Counselling has developed apace to the limit of the capacity of the trained workers available and it is not surprising that consideration should sooner or later be given to the extension of this work by the schools themselves. There has, of course, been a parallel development in schools of youth counselling work and the two came together in 1969 in 2 one-day conferences aimed at stimulating interest in this subject amongst secondary school teachers. It was of great value to several of the medical and nursing members of the Health Department staff to be able to attend these gatherings since the third area of activity in this field of work is that of the Health Visitor/School Nurses who have included Personal Relationships in many cases in a wider programme of health education in schools.

An interesting convergence of Marriage Guidance Council and teacher counselling work is recorded by Mrs. J. Perry, who is the Honorary Secretary of the Barrow and District Marriage Guidance Council, in her account of the Council's activities during the year:—

> "One of our counsellors lives at Ravenglass in Cumberland, and does work for us in the Egremont Comprehensive School. In the past the counsellor concerned worked at the school solely for the purpose of leading discussions on family relationships. About a year ago she was employed by the Education Committee in the Biology department and she still holds classes in social studies when she leads discussions in line with our Marriage Guidance Council practice. She completed 46 sessions last year.

Two couples have been counselled from Millom during 1969. Counsellors have taken part in "Brains Trusts" at the Bootle branch of the National Farmers' Union, Ladies Section, and Thwaites Women's Institute."

The Catholic Advisory Council formed in 1963 is now no longer functioning and its future role is at present under review. The following table provides an indication of the number of new cases dealt with annually since 1961.

Carlisle, Cumberland and Eden Valley Council

Year	Carlisle	Workington	Penrith	West Cumb. Couples seen in Carlisle	Catholic Advisory Council	Total
1961	49*	—	—	—	—	49*
1962	57	—	—	—	—	57
1963	55	19*	—	—	18	92*
1964	15	36	—	—	15	66
1965	39	39	—	—	3	81
1966	42	17	—	—	2	61
1967	28	14	—	—	—	42
1968	40	15*	3*	16	—	74*
1969	19	1	8	6	—	34

* Part year only

It will be seen from the table that the Workington branch of the Council commenced in 1963. As it has now ceased to function, West Cumberland people are having to travel to Carlisle. This has doubtless affected the total number of Cumberland new cases in 1969 which is reduced although, as the secretary's report shows, the overall figure has increased for the Council as a whole, taking account of services to other local authority areas.

I am indebted to Mrs. Slee who has taken over the secretariat of the Carlisle, Cumberland and Eden Valley Marriage Guidance Council, for the following account of the work done by the Council during the past year:—

"The work of the Carlisle, Cumberland and Eden Valley Marriage Guidance Council during 1969 centred at Carlisle and Penrith has followed a similar pattern to the previous year.

The number of cases opened was 73 involving 125 children of whom 34 were cases from the county area.

There were 224 interviews given by the Counsellors, approximately half of which involved county cases.

The work of the Educational Counsellors during the year has covered a wide field in City and County involving group discussions at schools, Youth Clubs, with student nurses etc. The number of sessions held was 189 with a total attendance of 1,151.

With a view to training selected teachers to teach on the subject of "Personal Relationships" in their own schools, 2 one-day conferences were held in November in Carlisle and West Cumberland, and were well attended by teachers from both the City and County".

VACCINATION AND IMMUNISATION

Section 26 of the National Health Service Act, 1946

"Every local health authority shall make arrangements with medical practitioners for the vaccination of persons in the area of the authority against smallpox and the immunisation of such persons against diphtheria".

VACCINATION AND IMMUNISATION

In certain respects the end of the year 1969 saw a watershed in the development of vaccination and immunisation services in Cumberland. This is largely because of the completion then of arrangements for the introduction of computer controlled call-up of children for all their immunisation procedures. Initially in the Southern Area, this arrangement will include the Northern and Western areas as well in the course of 1970, and I look forward to reaping the benefits of the not inconsiderable amount of work which all of this has entailed. For the co-operation of many people I am grateful to notably my colleagues the County Treasurer and his staff who control the County Council computer and with my own staff have undertaken the detailed planning of the exercise. A unique feature of this scheme is the fact that it produces an entirely new situation with regard to the medical management of vaccination and immunisation for the individual child. This will henceforth be exclusively the province of the family doctor and to them for their co-operation and interest I also offer my thanks. The concentration ultimately of all vaccination and immunisation work through this scheme upon the group practice with its nursing team is in my opinion both an inevitable and advantageous advance. Mothers no longer face any confusion as to the role of the Medical Officer of Health (this is now purely organisational in the 'back-room') and the family doctor. The regular and more comprehensive attendance of children at the surgery for immunisation purposes will, I believe, bring and keep general practitioners increasingly in touch with all the children in their practices and so contribute to the next major advance in child health services development viz. the concentration of primary screening of child health, both school and pre-school, in the hands of family doctors. There seems no reason why automatic data processing techniques should not progressively be applied to many other fields where regular attendance is desirable at set periods at a group practice or health centre.

The universal application now throughout the County of the latest recommended schedule of immunisations, adapted marginally to fit the computer programme, progressively takes immunisation procedures out of the school till ultimately all re-inforcing doses will

be given in the group practice centre either just before school entry or at about the age of fifteen. This comes about because the age recommended for re-inforcing doses make it possible so to plan.

The first year of operation, however, of the new immunisation schedule preceding the introduction of the computer call-up scheme, has led to a certain lowering of some of the figures for 1969. This comes about because of the fact that it now takes between six and nine months for any child to complete a primary course of diphtheria/tetanus/pertussis and polio protection. Again the absence in the new schedule of an 18 month re-inforcement against diphtheria/tetanus/pertussis reduced the total numbers of re-inforcing injections given.

The programme of measles vaccination was sadly interrupted in March. 1969, by the withdrawal of the vaccine then being used. Between January and March, 1.391 children between the age of one and fifteen were protected. Not until August did very small quantities of measles vaccine begin to become available again; and only at the time of writing this report (April 1970) have the necessary quantities come through to enable the area medical officers and the general practitioners to pursue again the completion of the programme begun in 1968. Thereafter, of course, children will receive measles vaccination during the second year of life as part of the wider programme referred to above. A total of 2,440 children had been protected against measles in 1969 by the end of the year.

Another important part of the programme of vaccination against infectious disease is that of thirteen year old school children against tuberculosis by B.C.G. vaccination of those found suitable for this by prior skin testing. 2.215 children were so vaccinated in schools in 1969 and in the reports of the Chest Physicians on pages 228 to 236 it will be seen that they undertake the B.C.G. vaccination of children and adults where appropriate in the case of contact with a tuberculosis patient.

Diphtheria Immunisation

The numbers of children immunised during the year were as follows:—

Primary courses—pre school children	2,080	(2,883)
Primary courses—school children	460	(530)
Reinforcing injections—pre school children	1,705	(1,847)
Reinforcing injections—school children	3,760	(4,047)

The figures in brackets show the corresponding numbers for 1968. The reduction in the figures compared with 1968 is related largely to the factors I have outlined above in connection with the new schedule of vaccination and immunisations.

Tetanus Immunisation

The numbers of children immunised in 1969 were as follows:

Prmary courses—pre school children	2,069	(2,877)
Primary courses—school children	507	(580)
Reinforcing injections—pre school children	1,719	(1,856)
Reinforcing injections—school children	3,950	(4,166)

These figures are generally very near to those relating to diphtheria as the majority of children receive the 'triple' antigen against diphtheria, tetanus and whooping cough.

Whooping Cough Immunisation

During 1969, 2,055 pre school children received primary injections protecting them against whooping cough and 1,624 reinforcing injections. Again the correspondence is very close with the totals for diphtheria/tetanus/ whooping cough, and protection does not require to be reinforced at school entry.

Poliomyelitis Vaccination

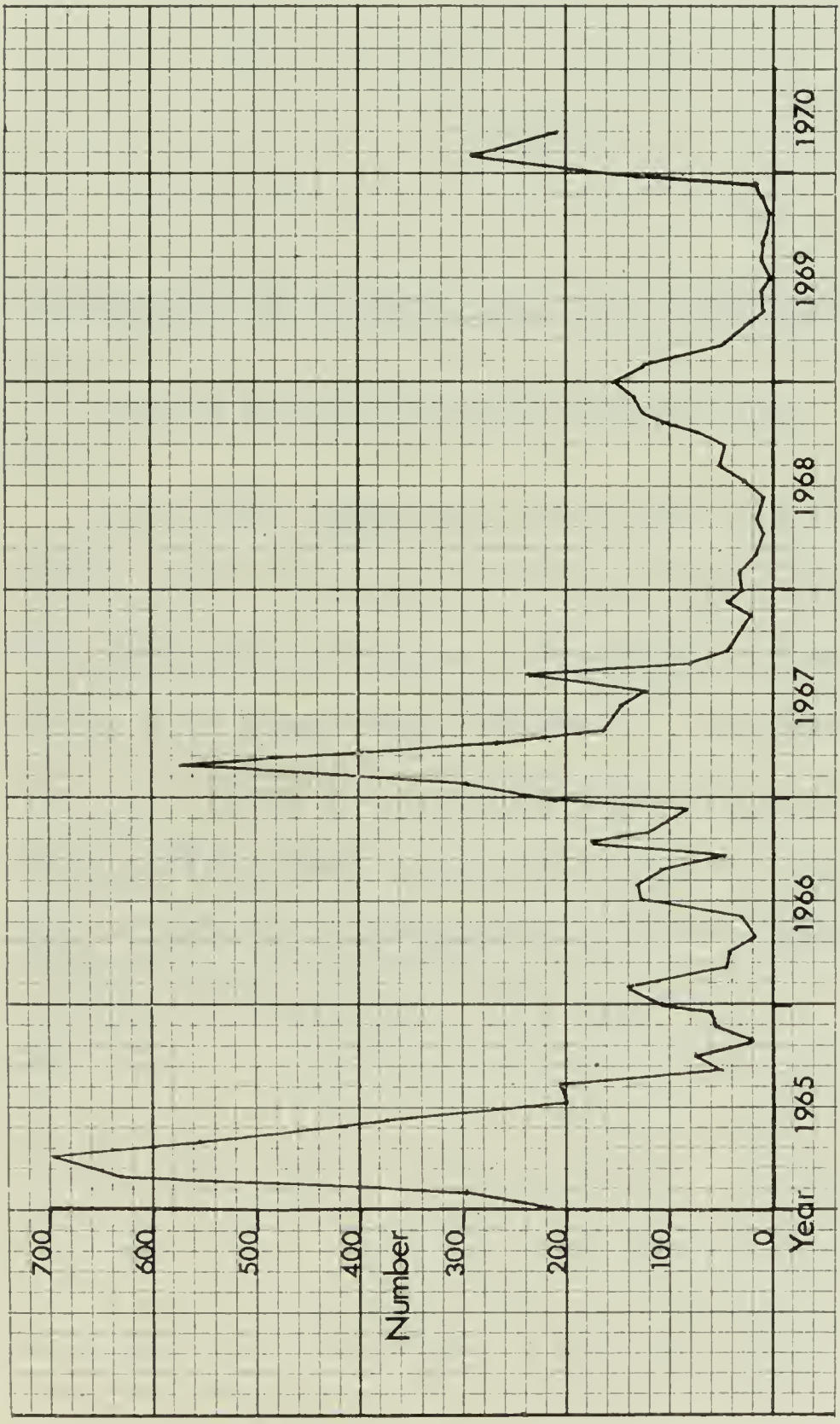
Primary courses—pre school age	2,200	(2,845)
Primary courses—school age	610	(770)
Reinforcing doses—pre school age	182	(163)
Reinforcing doses—school age	2,947	(2,622)

The same factors have affected the polio vaccination figures as are mentioned in connection with diphtheria, tetanus and pertussis.

Smallpox Vaccination

There was a total of 1,587 children vaccinated in 1969 against smallpox. This compares with a 1968 figure of 1,726. This remains too low for safety and I am glad this vital factor in community protection against infection is also included in the computer programme.

MEASLES NOTIFICATIONS — CUMBERLAND



PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Section 28 of the National Health Service Act, 1946

"A local health authority may, with the approval of the Minister, and to such extent as the Minister may direct shall, make arrangements for the purpose of the prevention of illness, the care of such persons suffering from illness . . , or the after-care of such persons, but no such arrangements shall provide for the payment of money to such persons, except in so far as they may provide for the remuneration of such persons engaged in suitable work in accordance with the managements."

PREVENTION OF ILLNESS, CARE AND AFTERCARE

In this section of the report I am indebted to several consultant colleagues for reports on services which have always had a prominently preventive aspect. Dr. Bell underlines the continuing and growing menace of gonorrhoea and the Consultant Chest Physicians reports leave no room for complacency on the grim facts concerning lung cancer in particular. Chiropody, cervical cytology, convalescence, physiotherapy and the use on loan of nursing aids. continue to contribute substantially to maintaining health and activity in various population groups; all health services to the community which if frequently unsung in comparison with more dramatic advances and techniques in medicine, are deeply appreciated by the individuals who benefit from them from day to day.

Cervical Cytology

During the year the total number of smears examined by the two pathology laboratories in the area was 13,575. Of these 5,011 were examined at the West Cumberland Hospital and 8,565 at the Cumberland Infirmary.

It must be appreciated that these totals refer to work done in the Hospital laboratories, not only for Cumberland women but also for those from several other local authority areas including parts of South Scotland. As far as Cumberland is concerned it will be seen from these figures and those shown below in relation to work in clinics, factories, homes and G.P. surgeries, that the volume of the work carried out in the community is increasing. I believe this is essential since a large proportion of the tests taken in Hospital are from women attending for some other reason; some of them of course, at routine post natal examinations. Those at risk in the community and with no cause to attend a hospital obstetric or gynaecology out-patients must be attracted to attend for cervical cytology at their doctor's surgery, their place of work where facilities can be provided, or in certain cases have the test done in their own homes.

County Health Department staff took 3,711 of these tests in Local Authority Clinics, Factories, Homes and G.P. surgeries.

This shows a substantial increase over the tests taken by County staff in 1967 and 1968 and compares with the number of tests taken in the peak year of 1966, as the following table shows:—

	1966	1967	1968	1969
Clinic and Factory ...	3,905	1,270	1,014	1,286
Home	155	81	32	22
G.P. Surgeries ...	Nil	391	1,187	2,403

There was a significant rise in the number of smears taken in G.P. surgeries which is reflected in the above table. This is probably a result of the publicity programme started in 1968 whereby G.Ps. and County Medical Officer jointly sent letters to women who had not previously been tested, making positive appointments.

The main concern this year was to plan some provision to contact the women due for a further test on a five year recall basis. This problem is a tremendous challenge to the resources available, for, in addition to the on-going testing ofwomen who have not previously had a test taken, there will be roughly 1,700 patients previouslv checked by county staff due for recall in 1970 and 4,000 in 1971.

It was with this problem in mind and in the absence of any national or regional recall scheme that I felt a local system had to be formulated. Initially the whole concept of any scheme had to take account of the way the problem could be met by the pathology laboratory, for this involved an extensive administrative exercise by laboratory staff. Many records of patients previously tested had to be checked against laboratory reports, and where necessary referred back to the gynaecologists for advice, the situation being further complicated by the existence of two laboratories in the area. Therefore a meeting was arranged with the consultant pathologist at the Cumberland Infirmary, in the first place.

The second problem to be solved was the mechanics of actually arranging the taking of the large number of retests which would gradually build up from April, 1970. This subject was discussed with general practitioner colleagues in the Local Medical Committee and agreement was reached that the recall of women pre-

viously tested in Local Authority Clinics or surgeries would be to the G.Ps. surgery where he, with the help of the local authority nursing team, would make the re-examination. The numbers, when classified by areas, practices and dates seemed quite manageable.

The arrangement agreed upon was that the laboratory would prepare lists covering all women who had tests taken five years earlier, whether at a local authority clinic or gynaecology clinic, the latter results to be screened by the gynaecologists so that any patients who were still under active treatment or under observation by them would be deleted from the lists. It was expected that the lists would quickly build up to approximately 1,000 per month and warning of the build up was given to the community nursing staff involved. The monthly lists of those due for recall are sent to each area health office where they are dealt with on a group practice basis.

It was agreed that there would be some value in small groups of nurses visiting the laboratory for education in the laboratory processes with a view to eliminating common errors in filling out cards; also that a further meeting should be arranged to discuss the scheme for any shortcomings once under way.

It is rather disappointing that no national scheme has so far been devised for the recall of women for repeat tests. It has been hoped for some time that such a scheme would emerge, based on computer call-up which would have access to nation-wide information. Until such an arrangement is arrived at local schemes for re-call such as I have outlined above will remain very imperfect; such schemes cannot take proper account of the movements of persons from one part of the county to another. Regard could be given to this and other factors in a national scheme, based on such information as changes in registration with family doctors.

Tuberculosis and Diseases of the Chest

To the Consultant Chest Physicians in East and West Cumberland I am again indebted for the reports printed in the Appendices. Dr. Hambridge maintains his close and very helpful interest in the epidemiology of tuberculosis in West Cumberland; and Dr.

Southern makes his first report this year for East Cumberland, having succeeded Dr. Morton in the course of 1969.

Nursing Equipment on Short Term Loan

Section 28 of the National Health Act, 1946 empowers local authorities to issue free and on temporary loan equipment for the care and aftercare of patients in their own homes.

District nurses have supplies of smaller items of equipment such as bed pans, air rings, plastic sheeting and back rests, but the larger items are issued through the British Red Cross Society who act as agents for the health authority. The County Council make a payment annually towards the cost of running depots situated in the north and west administrative areas of the county as follows:—

Carlisle—		
2, Chatsworth Square.	Monday—Friday	10.0 a.m.—12 noon 2.0 p.m.—4.0 p.m
Workington—		
59 Station Road.	Tuesday & Thursday	10.0 a.m.—12 noon

All enquiries regarding loan equipment in the Southern administrative area should be made to Flatt Walks Clinic, Whitehaven.

In the past year there were 752 items of equipment issued of which 456 were major items.

These loans are, however, of a temporary nature and patients who are hospital in-patients, or out-patients, and are considered to need permanent loan of such things as invalid chairs, or walking aids, will obtain them from the Ministry of Health and Social Security on the certification of a hospital consultant. It is essential that a measure of flexibility exists between the local authority loan equipment scheme and that of the hospitals, and in 1964 agreement was reached by the County Council and the East and West Cumberland Hospital Management Committees regarding the provision of short term and semi-permanent, long term, loan.

The following table gives details of the type and quantities of nursing requisites which have been made available in 1969.

It will be seen that the number of wheelchairs issued this year is not as high as usual. Patients are being encouraged to approach the hospital authorities regarding the loan of wheelchairs where it is evident that the loan will be on a semi-permanent basis.

Equipment	1965	1966	1967	1968	1969
Commodes	145	141	129	123	100
Crutches	62	31	31	67	48
Hoists, hydraulic ...	—	—	3	9	4
Hospital beds ...	10	12	7	21	12
Invalid chairs					
Adult type ...	176	167	127	129	76
Junior type ...	22	5	9	13	4
Mattresses					
Rubber ...	15	14	8	23	11
Inflatable ...	3	3	—	1	—
Hair	—	—	—	1	—
Walking Aids ...	150	159	153	95	201

Requests for this type of equipment are generally made by the hospital, general practitioners or nursing staff.

The steady demand for items of nursing equipment bears witness to the continuing volume of care within the community.

Hoists enable some of those suffering from such complaints as multiple sclerosis to be nursed within the home. Walking aids are used in many cases of stroke rehabilitation or arthritis. This is one item of equipment which is not supplied by the hospital authorities.

Patients or their relatives are expected to return equipment as soon as the need for it ceases, but following the death of a patient recovery of the equipment is frequently effected only by reference to the death return or by members of the nursing staff. As an additional safeguard there is a routine annual check of all equipment on loan to ensure that it is still required.

The loan equipment service is complementary, and an invaluable ally, to a highly developed community nursing service.

Domiciliary Physiotherapy

A limited domiciliary physiotherapy service continues in three areas of the county in close association with group practices in these areas. This service has not been extended during 1969. Although an extension would be welcome in other parts of the county the scarcity of physiotherapists makes one reluctant to attempt to attract too much of this work away from hospital departments where therapists' time can in many respects be more economically used. I believe there will be a slow development of domiciliary physiotherapy through the services of married ladies whose home situations may make it more suitable for them personally to work in the community rather than in hospital.

In connection with the good work which the two part-time therapists do at present, I am glad to know that an improved department of rehabilitation is now being planned at Whitehaven hospital. I am sure a secure link between the work of this department and the limited amount of domiciliary physiotherapy will prove very profitable for many patients.

Convalescence

The number of admissions to homes for convalescence care this year was 39. The decline in the use of this service can be seen from the following table.

	No. of Admissions
1964	83
1965	144
1966	99
1967	49
1968	55
1969	39

All of the admissions were to the Silloth Convalescent Home. Making most use of the service was the Northern Area of the county who sent 21 persons, Western area sent 11 persons and Southern area 7 persons.

In recent years restricted financial provision has been necessary for this and many other services. As a result family doctors recommending patients for convalescence have had to apply very

strict criteria of selection and this has resulted in a decline in the numbers entering the home who are supported by the Local Health Authority.

Chiropody Service

The authority's chiropody service for the elderly, the physically handicapped and expectant mothers, has continued to expand, although the rate of expansion of slightly less than 1% in 1969 is the lowest since the service began in 1960. After a rapid rate of growth in the early years it seemed that it had settled at about 5% per year and the reason for the recent slowing down is not clear. It may be associated with staffing difficulties, or it could well be that the plateau in referrals has been reached and that in the future new patients will do little more than replace those removed from the list, mostly on death. I am assured by the chiropodists that the introduction of a charge of 2/6d. per treatment does not seem to have had any effect on the numbers availing themselves of the service.

At the end of the year there were 6,300 patients, although throughout the year a total of 6,400 patients received 25,869 treatments. This was substantially fewer than the number of treatments one might have expected and is indicative of the staff shortage whch prevented many patients from getting the usual six treatments a year.

While the service caters also for the physically handicapped and expectant mothers it is, for all practical purposes, a service for the elderly. Only 8 expectant mothers and 114 handicapped persons were treated.

The patients certified by their general practitioners as being in need of domiciliary treatment comprise 27% of the total referrals, which is in line with recent years. There is still no indication as to why referrals for domiciliary treatment should be at the rate of 23% in the southern area of the county, 26% in the northern area and 35% in the western area, which is more compact and better served by public transport than the other areas.

During the course of the year the authority considered again the further implementation of its policy to move towards a service

staffed by full-time chiropodists. As a result, the establishment of full-time officers was increased from six to eight and, at the same time, it was agreed to reduce the maximum case-load of patients who could be treated under the county's scheme by chiropodists in private practice to 300 per chiropodist. When these decisions were made there was a full complement of chiropodists and it was confidently expected that another two could be recruited. Unfortunately, two left the authority's service and there was some difficulty in replacing them, resulting in severe restriction on the service provided in certain parts of West Cumberland. At the time of writing there are seven full-time officers in post and it is hoped that it will be possible to resume regular treatment for those in need at an early date.

In view of the difficulty in recruiting the necessary full-time staff no action was taken regarding the reduction of patients being treated by chiropodists in private practice and implementation of this will, in fact, be left in abeyance until there is a full establishment of whole time officers.

At the end of the year there were 4,157 patients on the lists of the full-time chiropodists and 2,136 being treated by part-time chiropodists who are also in private practice. This suggests that the eleven part-time chiropodists have a whole time equivalent of about four.

Treatment, whether from full-time staff or part-time staff, at clinics or in practitioners own surgeries, is available at the following centres:—

Alston
Aspatria
Brampton
Carlisle
Cleator Moor
Cockermouth
Egremont
Keswick
Longtown
Maryport
Millom
Penrith
Salterbeck
Seascale
Silloth
Whitehaven
Wigton
Workington

Chiropodists also visit all the authority's Old People's Homes.

Early in the year a survey was undertaken to provide information about the time chiropodists spent on treatment and how the remainder of their time was divided between travelling, clerical work, etc. On practical grounds the survey was limited to full-time staff. An analysis of the records kept specially for this purpose during the fortnight beginning 20th January, shows that on average 67% of the time is spent on treatment, 14% on travelling between clinics and in connection with domiciliary visits, 10% on clerical work and 9% on "other duties". This latter category covered the time spent preparing surgeries, dealing with enquiries and the time wasted due to patients arriving late, broken appointments and abortive domiciliary visits.

These figures are roughly in line with those produced in a survey carried out in 1967.

The time spent on travelling seems high at first glance but when it is borne in mind that over a quarter of all patients have, on their doctor's recommendation, to be visited at home and that in this rural county such visits can involve substantial mileage the 14% becomes not unreasonable. It does, however, illustrate the price to be paid in chiropodists' time and travelling expenses to see patients at home rather than in the clinic. It also raises again the perennial problem of transport for those domiciliary patients who could go to clinics if door to door transport was available, and in this connection Mrs. D. E. Smart, M.I.C.Ch., S.R.Ch., says:—

> "As is to be expected, each year we find a percentage of clinic patients being transferred to the domiciliary list, age and infirmity resulting in inabilty to get to the clinic by public transport. If we could have the co-operation of voluntary services in providing transport for these patients it would be a great help."

Such arrangements do exist in one part of the county and it is hoped to extend them.

The amount of time which the highly trained chiropodists spend on routine clerical work is a source of concern but I am satisfied that these functions have been reduced to a minimum. The

possibility of employing clerical assistance to release the chiropodists for their true functions has been examined carefully, but in general the clerical work is carried out in many short periods and to have other staff to do this would not, in fact, make the chiropodists available to do much more chiropody.

This was, however, taken into account in some measure in a pilot scheme of operating a two-chair system which was carried out by Mr. G. H. Thomas, M.Ch.S., S.R.Ch., at Flatt Walks Clinic, Whitehaven. The scheme was introduced primarily to cope with the additional work load during a period of acute staffing difficulty and has proved successful in enabling the chiropodist to treat more patients than would otherwise have been the case and to do so economically. The chairside assistant who was appointed for this purpose helped the patients with shoes and stockings, collected the fees, made the new appointments and cleaned up the chairside area between patients. As this system needs a duplication of equipment it can really only be operated economically at the clinics which are in regular use and which have the necessary additional space available. The intention is to introduce the two-chair system wherever it seems effective to do so.

The time which the survey revealed to be wasted is, at 9%, not unduly high when one considers that the patients are almost all elderly and that the survey was undertaken in the middle of winter. Mr. Thomas has found that the absentee rate is, throughout the year, just under 10% and that this is marginally lower than in previous years.

Mr. W. W. Gordon, M.Ch.S., S.R.Ch., is rather concerned about the referral of patients for no more than nail-cutting, a service which could equally well be provided by relatives and others. He writes:—

> "Palliation by protective and cushioning pads plays an important part in our every day treatments and these form an extremely useful and beneficial part of our armament in relieving the crippling foot defects found in the elderly patient.

However, this form of care and attention, essential as it is, in many cases carries with it the idea that chiropody is a comfort service only and that the extent of the chiropodist's skills are limited to cutting toenails and paring corns and overlooks the preventive and curative aspects of our daily routine.

Recent developments in appliance therapies and techniques, to take only one example, have considerably enlarged our capacity to undertake positive curative and preventive measures. It is in this field that we have endeavoured to find new skills and procedures which will take chronicity and the need for repetative visits away from those elderly patients who suffer from the painful immobilising foot defects that come within the scope of our work.

In this we have been more than moderately successful! The use of nail brace techniques to correct involuted nails which lead to onychoposis and onychocryptosis and other irregularities, are encouraging.

The expanding use of thermo-plastic materials and silicones in appliance and digital protection and correction gives us confidence that we shall be recording more and more progress in this direction."

On the use of thermo-plastic materials Mr. G. H. Thomas reports:—

"In the last report I wrote of the introduction of the use of Plasterzote as an appliance medium. During the past year I have used this for the making of insoles with great success. It is much cheaper than the more conventional leathers and rubbers, and whilst its durability depends very much on the amount of pressure and friction it has to endure it compares very favourably with them.

The recent instalment of a Plasterzote oven at Flatt Walks has already opened up a further vast field in the use of Plasterzote for moulded foot and digital appliances and will further reduce the use of less permanent and more costly materials.

I am confident that the introduction of this technique will be of tremendous benefit to the patients and I am grateful to the authority for their backing in this project."

Two of these ovens have been purchased and are based at Whitehaven and Workington.

Although there are, overall, comparatively few patients within the category of physically handicapped, Mrs. G. Garrett, M.Ch.S. S.R.Ch., has a relatively high proportion. Of them she says:—

"A number of physically handicapped are being treated, the bulk of these being either osteo/or rheumatoid arthritis cases. At the lower end of the age scale we have some of the residents at Alneburgh House, Maryport (the authority's Home for Younger Handicapped) who, though their disabilities are acute, make one of the liveliest of sessions with the skilful and speedy progress of their wheelchairs down the corridor."

The chiropody service is now, in Cumberland, an established and accepted part of the local authority health services, a part which is by all accounts much appreciated by those who need its services. Staffing will undoubtedly be the key to its future development, quantitively or qualitively.

Venereal Diseases

The following is an extract from the report of Dr. H. J. Bell, Consultant Venereologist to the Special Area Committee of the Newcastle Regional Hospital Board:—

"Comment on the work of the Special Clinic at the Cumberland Infirmary, Carlisle, must be dominated by one item—the distressingly large increase in the figures for gonorrhoea. The totals for 1969 were 60% above those for 1968. At the time of writing, the national statistics for England and Wales are not yet available but, judging from the Quarterly Returns up to the end of September, the picture is still one of marked increases. I should predict that the National Table published for 'Infectious Diseases' for 1969 will show gonorrhoea in top place, and measles relegated to a secondary position. Perhaps this new placing of the gonococcus

at the head of the 'league table' will underline, more forcibly than before, the menace that this disease represents to our civilisation—and the urgency for large-scale research (and, equally large-scale monetary backing for such research) in an attempt to ameliorate what some doctors in these days refer to as a 'pandemic', but which would be better described as a modern plague.

Early syphilis is still very rare. Only one case was treated at the Clinic in 1969, but this was a seaman who had contracted his infection in Brazil.

During the year, I was given the opportunity of studying the method of making the diagnosis of gonorrhoea in female patients—normally a notoriously difficult and unreliable procedure by routine methods—using the technique of immunofluorescence. Unfortunately, this method is still somewhat too elaborate and too time-consuming for use in my provincial clinics, and will require to await further simplification before it can be adapted usefully in this area.

I had anticipated that two of the more modern medical phenomena of our times might influence the work in the V.D. Clinic during 1969. I wondered, for example, if I would become involved with drug-taking among the younger age-groups. Drug addiction was not in evidence among any of my patients from Carlisle itself, although some of the students who live 'rough' in the Keswick area during the summer months admitted to me that they had been approached by drug peddlers in that district. One girl of fourteen years of age, referred from our local Remand Home, had absconded from her family in Cumberland, and had been picked up by Social Workers in Piccadilly. Her short association with the 'hippies' there, and their use of drugs caused such an impression that she had already developed an acute phobia at the mere sight of a syringe and needle, before she was brought to be for examination.

As far as I am personally aware, then, drug-taking such as it is in Cumberland, has not been reflected in the situation at the Clinic so far.

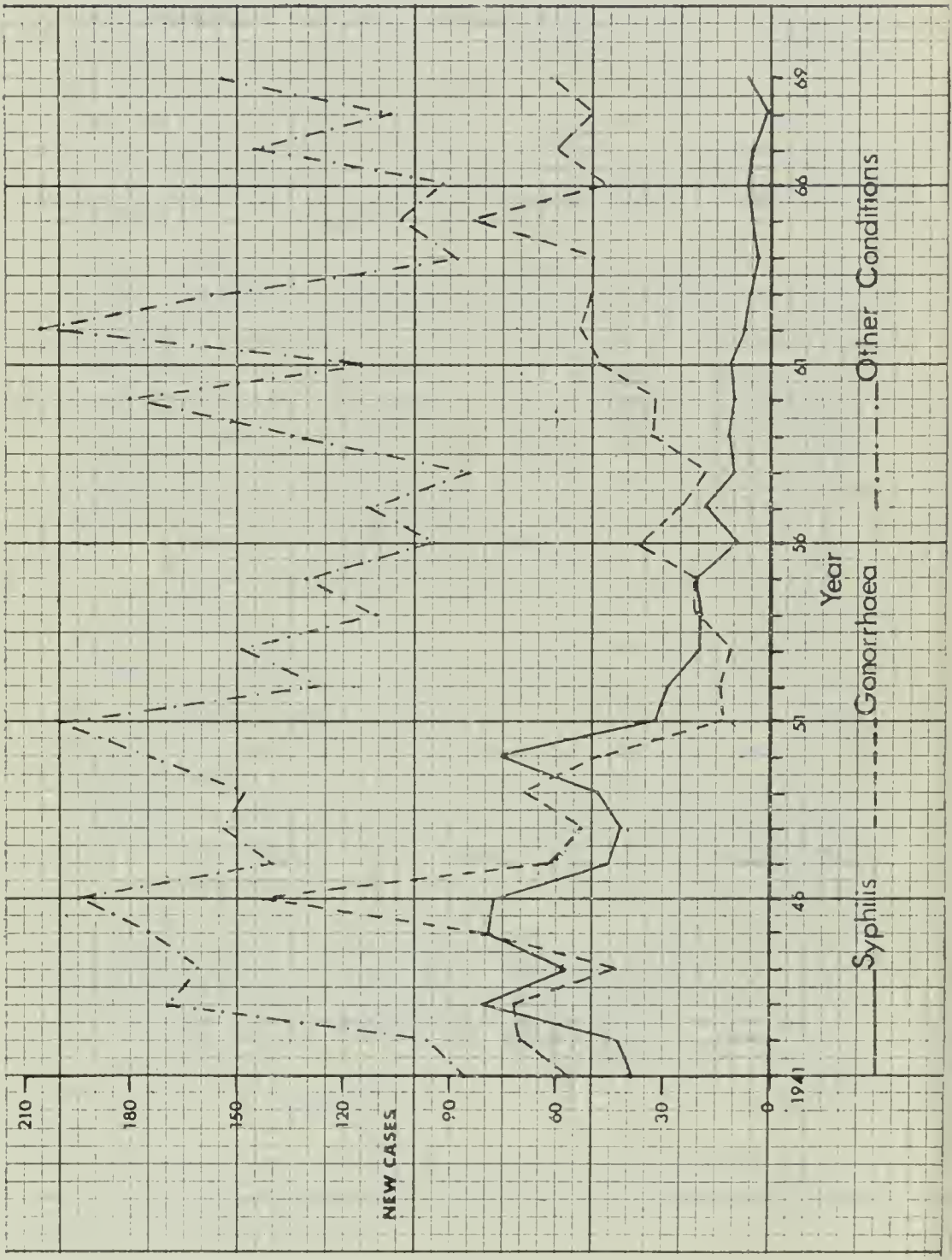
The other phenomenon of our times is, of course, contraception on such a grand scale.

I examine a fair number of women, both married and unmarried, who have been fitted with the intra-uterine contraceptive device (I.U.C.D.). I have little doubt that the 'threads' which are left dangling through the cervical os irritate the area so that the cervical smears which I take from there, in my search for gonorrhoea, show a greater profusion of mucus, pus cells, and excoriated epithelial cells. This is not a serious problem, but it is a nuisance to the Clinician, because the search for the gonacoccus is difficult enough without this plethora of cytological elements clouding the microscopic examination. What is more serious is the probability —reported by a number of my colleagues—that a woman who contracts gonorrhoea, if she is wearing an I.U.C.D., is much more liable to develop the complication of endo-salpingitis. After all, it is the possibility of salpingitis which warrants the opinion that gonorrhoea is the most menacing infectious disease of the day. Numerically speaking of course, it is the most important infectious disease, along with measles.

The oral contraceptive presents difficulties of a different kind. Primarly the 'PILL' threatens us because it gives a false sense of security and promotes wider promiscuity. In the past older mechnical methods of contraception gave, at least, some protection against contracting venereal disease. It is inevitable, I would think, that as the use of the 'Pill' becomes more and more popular, so, likewise, will the contagion that is gonorrhea become more widespread.

The graph on page 136 shows the new cases of venereal disease in Cumberland from 1941-1969. This represents only cases whose normal place of residence is in the administrative county of Cumberland.

VENEREAL DISEASES—NEW CASES PER YEAR
1941 to 1969
ADMINISTRATIVE COUNTY OF CUMBERLAND



WELFARE SERVICES

WELFARE SERVICES

There is, I believe, ample evidence in the report which follows of my concern to develop as rapidly as possible the services in the community for the physically handicapped. Nevertheless, in many respects it is still community care of the elderly which demands a large share of the resources of the welfare services. It could not be repeated too often that 95% of elderly people are living in their own homes or with relatives in the community and for their care there must be mobilised the global resources of the community in which they live. This means the under-girding of relatives, friends and neighbours through such services as Meals on Wheels as well as the maximum support for other voluntary bodies and individuals who are fortunately willing and eager to contribute to the care of elderly people. Then comes the structure, extent and development of statutory services, especially charged with this growing responsibility. There is no doubt that only the maximum support and integration of all these three elements will enable the developing situation to be coped with in the years ahead. All of this in principle applies equally to the care of handicapped and disabled people of all ages in the community.

Within the sphere of the statutory welfare service one of the major problems is the balancing of resources between domiciliary and residential services. With regard to the former, the body of field workers in the person of community nurses and social workers continues to build up steadily, if slowly, and this is coupled with an increasing sophistication of the techniques which they employ. The regular screening of the circumstances, physical, mental and social of elderly people at specified intervals continues to expand on the only possible satisfactory basis, namely that of the family doctor group practice team. Improved patterns of assessment, both at this stage and with the help of the hospital specialists, is required and must inevitably follow from this and there is evidence that this is already happening. Schemes are being advanced moreover during the year for the provision of special supportive facilities for elderly people ready to leave hospital and return home given the adequate domestic conditions for this.

The evidence accumulates all round of the growth of the problem of the psycho-geriatric patient. The clamant demand of

the hospital service for increased accommodation for these patients, preferably outside of large mental hospitals which can not but be remote from the homes of many patients, is becoming ever more pressing. This is in marked evidence in the West Cumberland area where possible solutions are under very active study. This matter has also been underlined by a very recent circular from the Department of Health to hospital authorities about the assessment of the psycho-geriatric patient. All of this but reflects the wider community demands for care in the home of these confused elderly people who, needless to say, make the most excessive demands upon the supportive services. Frailty of mind very soon requires round the clock care of some kind for an elderly person and the limitations of the domiciliary services in providing this are apparent.

This leads to a general comment on the situation in the county with regard to residential accommodation in old people's homes. The unhappy legacy of the years, in the shape of ex-public assistance institutions, having finally been laid aside with the closure of Highfield House, Wigton, as 'Part III' accommodation, it is encouraging to look forward to a real growth in future years of first class residential accommodation. Regarding the county overall, the number of places available in old people's homes is now the same as it was in 1966 but the disadvantage of this in pure numerical terms must be off-set by the improved quality of accommodation which I have mentioned and also the greatly improved quality and spread of domiciliary care, also touched upon above. It has been inevitable that the waiting list for places in old people's homes has almost doubled in the last four years. In crude numerical terms there are approximately 150 elderly people awaiting admissions at present, of whom about 20 on average are occupying hospital beds. Furthermore, the waiting period has increased from .46 years to 1.08 years between 1966 and 1969. Inevitably some who would ideally, at an earlier stage, be accommodated in an old people's home find their way into a hospital bed before the former becomes available. Yet it is doubtful whether this occurs in many cases who would not, at about the same stage, require a period of hospital care from an old people's home. The fact is that new, urgent cases requiring immediate admission to an old people's home are extremely rare in the community and this

indicates clearly to me that the basic requirements of community care are being met.

I feel that some of the demands of social workers for greater immediate availability of places is associated with limited experience and training; especially in relation to the definite increase in the incidence of senile dementia with which they are now coming into contact. Indeed the interface between old people's home accommodation and hospital geriatric beds is almost as wide as the entire problem itself. One is hard put to distinguish in many cases between the degree of disability and dependence of the occupants of old people's homes and hospital geriatric units. Drastic and repeated appraisal has been necessary over the years with regard to the type of individual accommodated in old people's homes until the position has been reached where it is no longer realistic to say that nursing, in the hospital sense of the word, is not required in some of the homes for some of the residents and this has, of necessity, stimulated a complete review of staffing structures in old people's homes. It is abundantly clear that the near future must hold a substantial increase in staff or a severe cut back in the admission and retention of severely infirm elderly people to the homes. No doubt a compromise will be reached between these two and all of this prompts me to put forward the suggestion that only a truly unified approach to the residential care, social and medical, of elderly people can hope to reasonably contain to-morrow's problems in this field and establish and maintain a just level of priorities for individual cases. It is with this in mind that I greatly welcome the recent encouragement from the Department of Health and Social Security to hospital authorities with regard to the pattern of assessment, out-patient and in-patient, of the psycho-geriatric cases. This is very much in line with the sort of need which I have been advocating with my hospital colleagues for a number of years in this area, although we have only moved so far, a very little way towards a planned comprehensive psycho-socio-geriatric assessment of elderly people. I believe that the emergence within 12 months of local authority departments of social services makes it the more urgent that medical assessment techniques are improved rapidly so that advice on this can be given medically with a single voice to the Directors of Social Services who may well administer old people's homes

in the future from a slightly different view point than that adopted at present by many medical officers of health/chief welfare officers.

Residential Accommodation

(a) For the Elderly

The provision of community supportive services for the elderly from both statutory and voluntary sources to enable them to continue to live in their own homes is the policy both nationally and locally. Only if and when this s impossible or impractical is an admission to residential care considered.

The total situation in relation to the needs of the elderl/ must be borne in mind in determining the level at which accommodation in welfare Homes and in supported housing schemes will be required. At any time it can be expected that 95% of the elderly population can be adequately maintained in their own homes, that from 2% to 3% will be inpatients in hospitals and that for just over 2% care will be necessary in either a residential Home for the elderly or in a grouped dwelling scheme which offers warden oversight.

The provision of residential accommodation for the elderly in this administrative county until 1952 consisted of three large former Public Assistance Institutions located at Whitehaven, Penrith and Wigton. When one considers the vast area of this rural sparsely populated county it is apparent that the majority of the residents admitted to these Homes had to divorce themselves from their native village or town when admitted. It is because of this that it has been the policy of my Committee during the past decade to provide small modern units of accommodation in each area.

The changing pattern of residential accommodation for the elderly during the past seventeen years is illustrated by the following table:—

At 31st December	Joint-user establishments	Number of beds provided: Adapted premises	Purpose-built Homes	Total
1952	325	—	—	325
1953	325	19	—	344
1954	325	19	—	344
1955	263	69	—	332
1956	263	69	—	332
1957	242	69	—	311
1958	242	113	—	355
1959	252	113	—	365
1960	215	113	38	366
1961	215	113	38	366
1962	117	113	114	344
1963	117	113	114	344
1964	117	113	114	344
1965	117	113	149	379
1966	117	113	189	419
1967	115	113	199	427
1968	60	113	259	432
1969	—	95	324	419

Highfield House, Wigton, the last of the former Public Assistance Institutions in Cumberland was closed for use as a Home for the elderly on the 10th July. 1969, the residents being transferred to a new purpose-built Home.

One of the adapted premises, an 18 unit Home at Kirksanton, was closed during 1969, and I believe that with a continuing increase in the number of purpose-built Homes the gradual closure of these adapted premises will be the trend during the 1970's. It has been said that yesterday's solutions are today's problems and this is certainly the case with the adapted premises providing residental accommodation for the elderly. Whilst it is true that most of these Homes in Cumberland are grand houses in delightful settings, the accommodation which they provide is now proving to be quite unsuitable for the degree of infirmity from which to-day's residents suffer. Just ten years ago new resdents at time of admission were on average in their late 60's or early 70's and could look forward to spending an average of ten years in their new home. Since that time, however, with the development of supported independency flatlet schemes, home help, meals-on-wheels, chiropody and other supportive community services the new residents to-day now average seventy-eight years of age and

can expect to remain in their new home for 2.8 years. It follows that their degree of infirmity on admission is much more marked.

While it is generally agreed that waiting lists for welfare accommodation are not reliable yard sticks by which to measure the need for residential care, some account, however, must be taken of these figures. The number waiting in Cumberland showed a marked increase during 1969. At the beginning of the year 110 people were listed for Part III accommodation. By the year end 154 were waiting admission, the highest figure being 163 in June. With this increase it becomes more necessary than ever to ensure that those admitted have the greatest need and to achieve this the aim is towards a positive pattern of planned assessment. Many people may be involved or have relevant information to contribute to this form of psycho-social geriatric assessment. In association with the consultants in psychiatry and geriatric medicine, the general practitioners and my own medical, nursing and social work staffs' procedures are evolved to ensure that accurate up-to-date information relating to all aspects of the problem is available and collated so that by accurate appraisal of the total situation the need can be identified and its degree of urgency more clearly defind. The large majority of residents are now admitted directly from hospitals or shortly after discharge from hospital.

The national trend for greater numbers of people to live beyond the age of sixty-five years is repeated in this administrative county as shown by the following table which includes an estimated projection to 1975:—

Year	Number of persons aged 65 and over
1961	25,497
1966	27,500
1969	29,000
1970	29,540
1971	30,080
1972	30,620
1973	31,020
1974	31,320
1975	31,620

The increased need for residential accommodation has resulted not only from the increased numbers of elderly people but also from the greater willingness to accept the residential provision which has resulted from the development of neighbourhood care Homes and the greatly improved standards of the accommodation provided. The closure of the former Public Assistance Institutions has worked a transformation in the acceptability of old persons' Homes and revealed the realistic desire and need for places. In an attempt to keep pace with this increased need my Committee have been very progressive and have always planned a most courageous capital development building programme for Homes for the elderly. During the recent national financial restrictions, however, these plans have been delayed by a year.

The capital development programme may now briefly be summarised as follows—in Keswick, a new 25 place Home is nearing completion and should be available early in 1970. In Workington building has started on a 40 place Home and this should be completed by January, 1971. The brief for another 40 place Home in Whitehaven will soon be submitted to the County Architect, and this Home should be in use early in 1972. Approval has been given by the Department of Health and Social Security for yet another 40 place Home to be located in Cleator Moor. This Home when completed in 1973 will mean that a total of 564 places will be available in Cumberland, i.e. 18.19 places per 1,000 of population over sixty-five years. While this is a marked improvement on the 11.3 places per 1,000 of population over sixty-five years which was the provision in 1965 it will still be short of the anticipated national average for 1971 of 20.2 places per 1,000 population over sixty-five years.

As previously mentioned the only remaining joint-user establishment, Highfield House, Wigton, was closed for use as a Home for the elderly. As it had provided accommodation for 60 persons and was being replaced by a new 40 bedded Home, "Inglewood", Wigton, from mid 1968 no new residents were admitted to "Highfield House". By the transfer date, 10th July, 1969, the number of residents there had been reduced to 39. To many of the residents, Highfield House had been their home for many years and it was considered essential that detailed preparations be made

to make the physical transfer of residents an uncomplicated and unemotional operation. The residents were advised of the transfer about a year in advance of the move. Some of the fitter residents quite rightly took it upon themselves to "supervise" the building of their new home and they kept the other residents and staff up-to-date with the progress of building. In spite of the fact that they would each have their own bedroom there were one or two residents who did not look forward to the move. Three days prior to the move all the residents' property, spare clothing, etc., was transferred to Inglewood and each was supplied with new clothing. On the 10th July, 1969, they were taken by bus to Inglewood in time for morning coffee. This was a very satisfactory exercise in human relations and the smoothness of the operation made all the time spent on planning very worth while. A few of the male residents still visit both staff and patients at Highfield House Hospital.

The new 40 place Home, Inglewood, Wigton, whilst complying with my Committee's policy to provide all single bedrooms has 4 bedrooms which can easily be converted by the removal of a partition to provide 2 double bedrooms should this be necessary for married couples. One new design feature at Inglewood is that fluorescent lighting is used throughout the circulation areas and lounges. In the lounges this is partially concealed peripheral lighting which ensures that the light is provided where it is most needed.

Reference to the closure of the adapted premises, The Croft, Kirksanton, has already been made. This was replaced on the 10th September, 1969, by a new 25 place purpose-built Home, Lapstone House, Millom, which also incorporates, in conjunction with Millom Rural District Council, a grouped flatlet scheme of 10 units which provides welfare support for the 12 tenants. The residents from The Croft were each taken round Lapstone House individually and shown their new bedroom before the move. On the 10th September, 1969, private cars were made available by the local Rotary Club, Inner Wheel, Knights of St. Columba and the Townswomen's Guild and each car conveyed a resident with his or her personal luggage. Again the transfer was very smooth. One or two of the residents having accustomed themselves to

multi-bedded rooms at The Croft were initially apprehensive about having single rooms but they all settled very quickly. The new Home has been accepted by the community and there are regular visitors to help with the serving of tea and a group of school children also visit regularly to assist in the Home. About 5 elderly persons from the area are regular attenders for day care. To date only 2 of the supported independency flatlet residents regularly use the television lounge each evening.

It is expected that The Croft, Kirksanton, will be taken over by someone who will use it as a private residential establishment for the elderly which will be registered as such under Section 37 of the National Assistance Act, 1948. Whilst The Croft has been withdrawn from use by this authority it compares very favourably with other private Homes for the elderly throughout the country and could in this new capacity provide a useful supplement to the residential care facilities for the elderly.

The circumstances leading to admission to full-time residential care for the elderly, are many and difficult. I can best explain some of these by quoting the facts leading to 3 admissions during 1969.

Miss X lixed alone for many years in a large three storied house, because of her decreasing mobility she gave up this house and went to reside with a nephew. After some months the nephew suddenly died and once again Miss X was alone being supported by domiciliary services.. A fall in the house resulted in her admission to hospital where it was decided that she could not return home. A vacancy was offered and Miss X has settled very well in her new surroundings.

Mrs. Y, an 86 year old widow living in an isolated area had been heavily dependent on her husband until his recent death. She would not accept his death and insisted that his "meals" should still be prepared. She refused to accept "Good neighbour" meals, home help, etc., she did, however, gradually accept that a neighbour light the fire each day. Meals were refused when delivered, and her diet was little better than bread, butter and tea. Finally she was so neglected that she was persuaded

to go into a Home. I am pleased to record that she has since taken on a new lease of life.

Miss Z, aged 76 lived alone in a village and, because of her eccentricity, was isolated by the villagers. Her neglected state was first noticed in 1967, although visited by the health visitor and social welfare officer she could not be persuaded to accept domiciliary help or treatment for her depression. In April, 1969, she reluctantly agreed to be admitted temporarily into care on condition that her house was repaired and cleaned. She was a very difficult resident, and after ten weeks, before the repairs, etc., had been completed she ordered a taxi and went home again refusing domiciliary support. Within three months, again in a very neglected state, after some hesitation, she agreed to be re-admitted as a permanent resident. With this final acceptance of her need for residential care her whole attitude changed and she is now happily settled.

I cannot close this section of my report without recording my appreciation of the very valuable contribution which is made by the Cumberland Federation of Women's Institutes, and in particular by their welfare secretaries. These volunteers are in close contact in every village community with the district nurse and, with their intimate knowledge of local communities, act as channels of information and communication with the statutory services for the care of the elderly. It is comforting to know that the tragedies of isolation are much less likely to develop as a result of their constant vigilance.

Out-county accommodation

Four former residents of Cumberland are resident in other local authority homes and 22 in homes provided by voluntary organisations. The authority has a clear statutory duty to accept responsibility for their maintenance and, so far as the elderly are concerned, arrangements for care outside the authority's provision are usually made in the area where relatives and/or friends are living. The others suffer from physical disabilities which are catered for in accommodation which is able to offer special facilities for such handicaps as cerebral palsy and epilepsy.

(b) **For the Physically Handicapped**

Alneburgh House, Maryport, a purpose-built 20 place Home for the younger handicapped was opened in June, 1968, and provides care for those younger physically handicapped adults whose disability is such that the degree of care and attention required cannot be adequately provided within the community.

Cumberland was one of the first local authorities in the Northern Region to provide this much needed service. At the early design stage it was decided that this Home should provide not only care but also a working environment where the potential of each resident could be fully developed. A large integral open planned workshop was therefore incorporated. Each of the 20 residents has a large bed-sitter type room which permits easy accessibility and movement by the chairborne resident. An open plan diningroom/lounge area also lends itself to the chairborne residents' needs and this large open area is most useful for social functions. Much thought was given to the design of the toilets and the inclusion of two "clos-o-mats" has greatly enhanced the resident' independence and morale.

As soon as Alneburgh House was opened the people of Maryport showed a lively, friendly interest in the well-being of all the residents. I am pleased to say that this acceptance and help to the residents and staff continues at a very high level and has largely contributed to the creation of a lively active purposeful atmosphere within the Home in the evenings and at weekends.

During the week days each resident is encouraged to go into the workshop from 9.30 a.m. to 12 noon and from 2 p.m. to 4.30 p.m. Initially persuasion had to be used to get one or two of the residents to take part in the workshop activities but with the introduction of sessional attendance payments and a system of incentive bonus the majority have now to be persuaded to stop in time for a wash before meals. It was decided that every penny accrued by the residents in the workshop would be returned to them in either cash or kind. In the workshop great care is taken to ensure that whilst the stimulus is to tasks demanding higher levels of ability, no resident tries to over-reach his or her capability.

In view of the expected degree of disability of the residents a small Advisory Committee was constituted to consider possible candidates for admission, and any problems or decisions regarding the residents. In addition to medical, nursing, social work and administrative representatives from my department, Dr. Kaminski, Consultant Geriatrician, West Cumberland Hospital and Dr. A. W. Rattrie representing the large group practice in Maryport very willingly agreed to serve on this Committee. Dr. Kaminski withdrew from this Committee in June, 1969, on the appointment of Dr. D. S. Wilson as Consultant in Physical Medicine and Rheumatology in Cumberland, and at this point I should like to record my sincere thanks to Dr. Kaminski for his professional advice and co-operation. In addition to attending the meetings of this Advisory Committee, Dr Wilson has now established a very valuable monthly clinic at Alneburgh House where detailed investigation of specific residents' needs are considered in depth.

It was decided that as this was the only Home providing a residential service for the physically handicapped in Cumberland, the best use of the accommodation would be provided by allocating 16 of the 20 places to long term residents, and the remaining 4 places to short term and holiday residents. During 1969, 9 short term and holiday admissions for periods up to three months were arranged.

At the beginning of 1969 there were 14 long stay residents, one of these residents was transferred to the Spastics Society's Industrial Training Centre, Lancaster, where it is hoped that further training will lead to his placement in either sheltered or open employment. Two long term residents were admitted during 1969, both came direct from hospitals. The average age of the long term resident is now twenty-eight years.

The residents as a group have worked extremely well showing a marked change in attitude over the months to group responsibility, workshop discipline and self-reliance. A great spur to their attitude to work was their ability to earn a small wage.

Social Activities

The socal life of the residents generally has undergone a subtle change in pattern, partly due to the individual resident accepting social freedom and the subsequent responsibilities, and partly due to their developing maturity and the whole-hearted support from the community.

Initially efforts were made to encourage group social excursions, but the emphasis is now veering more towards individual activity within their own circle of friends sharing their common interests. In developing this trend one had to consider the individual's degree of handicap, age, educational background, hobbies, interests, and religion, in an attempt to steer them in the appropriate sphere where social contact can be made to suit their personality and ability. This form of social integration has been successful with all but two of the long stay residents. Attempting to influence friendships must, of course, be done with the utmost discretion and help has been sought and obtained from a very broad cross section of the community, and in particular the church organisations and youth clubs.

Social contacts for short stay residents are of the utmost importance, as in the majority of cases one can expect that they will be returning from time to time, and may eventually return for a more permanent stay. When the time comes for them to accept a more permanent parting from their own family circle acceptance of residential care is easier if they are surrounded by a circle of friends outwith the Home.

Group social activities although decreasing in frequency are not totally excluded and have ranged through a wide variety of functions from pop group entertainment, monthly film shows and a weekly art class. To foster a competitive spirit an indoor air rifle shooting range has been set up in the workshop. This, of course, has only been possible by giving adequate instruction and supervision and we are indebted to Mr. J. Wood of Maryport, an ex-Queen's Marksman, for this very valuable service.

The range of social activity by the residents covers the normal family pattern—shopping expeditions—doing their own errands—

going to the hairdresser—and attending private and youth club dances. Most important of all is the activity involving family units, invitations to individual homes and sharing in family interests and outings.

The initial support received from the youth of Maryport, has I am proud to state continued at its original high level. The flow of helpers through the doors of Alneburgh House, has been steady and their enthusiasm and friendship has always been to the forefront. Group activity organised by the Youth Leader (Mr. J. Colman) and members of the All Souls' Youth Club included a sponsored walk in April which raised £600. The Foot Racing Association organised a sports day in August and this raised £25. By the end of August the Transport Fund had reached £1,300 and in October a small bus was purchased. This has a rear lifting platform so that chairborne residents can be carried. Areas of Lakeland have been explored and social functions can now be attended as a group.

There has, however, been a dramatic increase of demand on the care staff during 1969. Basically because of the increase in paraplegic type conditions and the increasing dependency of the residents suffering from progressive neuro-muscular conditions, plus an increased incidence of acute short term illnesses. To cope with the increased work load a part time district nurse was seconded from the community care nursing team to undertake nursing care of the residents and instruct the care staff in the broad principles of management and care, particularly as applied to progressive conditions and paraplegics.

The system of group practice coverage for the day-to-day medical care has worked extremely well, particularly helpful is the co-operation from Dr. A. W. Rattrie.

Having our own seconded nursing staff reduces the contact with the nursing team, but a very close liaison is maintained through the Area Nursing Officer and the local nursing Group Adviser. The same close co-operation applies to the welfare staff and Mr. Reeves, the local officer responsible visits on average three times per week.

An interesting development was the three times per week visit for day care of a long stay patient from the Younger Chronic Sick Unit at West Cumberland Hospital. This action was taken principally to aid the transition period and lessen the problems that would occur if and when he was transferred as a permanent resident, and to widen his horizons after a protracted stay in hospital.

Workshop Activities

The tasks undertaken in this sphere have ranged from car battery top assembly, the packaging of crayons, assembling and inspecting salt and pepper pots, typing labels for advertising brochures and sorting them for despatch by post and the manufacture of slate products.

The flow of work has been steady, but the availability of work is dependent on local factory conditions and a great number of factors over which the management have no control being subsidiary factories of parent groups.

Mr. W. L. Anderson, Matron, reports as follows:—

"During the first complete calendar year the size of our family has not changed greatly, with the fairly static numbers of long stay residents, policies can be implemented regarding degress of social freedom and attitudes to encourage the essential family atmosphere. The following principles are applied in their fullest sense.

(a) The problems of every handicapped person are highly individual and personal.

(b) The best solution for any handicapped person is that one which is as near normal as possible.

(c) A large amount of improvisation will be necessary.

(d) Great determination and singleness of purpose is essential for success.

(e) To approach an individuals personal problems as one would attempt to smooth out a difficulty within ones own family, particularly regarding self-discipline and consideration of fellow residents.

By applying the above principles some of our residents are experiencing a new found freedom by self-reliance and are exercising a greater degree of self-discipline. It, therefore, follows that the problems of staff/resident relationships are diminished but when clashes of personalities do occur the situation is more controllable.

Club organised social functions have been supplemented with dances and pop group sessions held both at Alneburgh House and at the Youth Club premises. The club nights are well attended by a few of the residents, particularly the younger ones and this gives them the opportunity of meeting their friends socially and accepting responsibility for programme planning for this purely teenage group.

In August the B.B.C. having heard of the activities at Alneburgh House decided that we should contribute to a Woman's Hour programme. A number of the residents joined Dr. J. L. Hunter (then Area Medical Officer) and myself in a recording which was broadcast in September."

Contact with relatives and parents

Although residents are strongly encouraged to look upon Alneburgh House as their home, emphasis is placed on the residents maintaining a very close contact with their families and friends. To this end many of the residents go home for weekend visits at regular intervals and occasionally, where possible, for holiday periods in the summer. This serves a double purpose, the family bond is maintained and the accommodation vacated can be used to provide for short term admissions from the community.

One of the residents makes the following comment:—

"I have been a resident at Alneburgh House for eighteen months. During this time my whole attitude towards life has changed. At Alneburgh House every necessary step is taken to care for everyone's individual needs. We have our own rooms, good food, a very high standard of care, a work room offering an income and social freedom without any book of rules. There is a family atmosphere about Alneburg House

and residents are encouraged to do what they can within the scope of their particular handicap. We have a great deal of contact with the people of Maryport without whose friendship and encouragement life would become quite dull."

Homeless Families and Temporary Accommodation

Local authorities have a duty under the National Assistance Act to provide "temporary accommodation for persons who are in urgent need thereof, being need arising in circumstances which could not reasonably have been foreseen or in such other circumstances as the authority may, in any particular case, determine". This service is available to those in need of it irrespective of their means.

This department gives a liberal interpretation to their responsibilities and provides accommodation for families under one or other of the following categories:—

(a) Families evicted on Court Orders;

(b) Families homeless by actions other than Court Order (fire, flood, family disputes, harassment by landlord, etc.);

(c) Families arriving in the county with no prospect of finding accommodation.

The very low incidence of homelessness within this administrative county has been maintained during 1969. Throughout the year only 33 families were notified to me as homeless or in urgent danger of being homeless and of these, only 12 families (consisting of 37 persons in all) had to be found temporary accommodation. The close family bond which still exists within this county is no doubt largely responsble for the small number of cases of homelessness reported. Having said this however, I must add that more than a third of all the cases notified during the year arose because of family disputes.

In Cumberland the casework and supervision of "problem" families is diversified between the Children's Department, the National Society for the Prevention of Cruelty to Chldren and the Health and Welfare Department. The provision of accommodation for homeless families and their supervision and guidance remains

the responsibility of my department. Seven families in which children were involved were maintained in their own homes under the rent guarantee scheme. There is good co-operation and co-ordination to unify the operation of the service, and it is pleasing to record that it was never necessary during the year to separate family units in any way because of homelessness.

Until June, 1969, the provision of temporary accommodation for homeless families had consisted of 3 purpose-built self-contained units within the grounds of the former Public Assistance joint-user accommodation at Highfield House, Wigton, and a small terrace-type house at Harriston.

Experience has shown that this concentration of homeless family accommodation at Wigton was not a satisfactory solution as it tended to aggravate the problem by separating the homeless family from their normal area of residence and employment. This point was made by the (then) Ministry of Health, the Home Office and the Ministry of Housing and Local Government in their joint circular of the 26th September, 1967, when it was stressed that a more satisfactory solution was for the District Council's to provide the use of intermediate housing as temporary accommodation. It was hoped that those authorities who have not so far found it possible to co-operate in this way would review their practice. Another important factor in favour of a decentralised concept of homeless family provision is that it is imperative that the family retains contact with their housing authority so that their prospects of being rehoused are not diminished. It is my experience that some County District Councils are reluctant to retain on their waiting list a family which is given temporary accommodation, on account of homelessness, within another housing authority's area.

When the welfare accommodation for the elderly at Highfield House, Wigton, was closed, leaving the East Cumberland Hospital Management Committee in occupation of the geriatric hospital provision, it was decided to close the three main units of temporary accommodation and my Committee resolved:—

(a) That efforts be made to rent, on a permanent basis, a local housing authority house, in each of the adminis-

trative areas of the county for use, as necessary, by homeless families;

(b) That each of the County District Councils be asked to make available at any one time, a house, on rental to the County Council, for families found to be homeless within their area;

(c) The transient homeless families be accommodated in private boarding houses.

In accordance with this decision the Clerk of the Council wrote to the County District Councils in August, 1969. Whilst all but two of the thirteen District Councils have so far indicated their agreement to co-operate with this request, I regret that by the 31st December, 1969, no house had yet been offered for this use. Let me record, however, that the District Councils (as housing authorities) take a most progressive and enlightened attitude towards the problem family and the homeless family. Two of the three families which had been housed at the temporary accommodation units at Highfield House, Wigton, were re-housed by the County District Councils when these units were closed. A house was rented in Whitehaven from the County Property Committee so that the remaining unit at Wigton could be closed and an unoccupied nurse's house in Abbeytown had to be brought into use for a homeless family for some six weeks pending rehousing by the District Council.

The temporary accommodation of families within private boarding houses has been a successful venture. Since authority to use this type of accommodation was granted in June, 1969, two families were accommodated for one night and two nights respectively, under arrangements between my officers and boarding house proprietors.

Meetings to discuss the problem of homelessness have been held at Whitehaven and Workington at the request of interested voluntary organisations. (The Cumberland Council of Social Service, Samaritans etc.) At these meetings I have emphasized the generous interpretation and acceptance of responsibilities taken by this Council regarding homelessness. Resulting from the meeting at Workington under the Chairmanship of Viscountess of Rochdale Chairman of the Cumberland Council of Social Service, a working

party on homelessness in Workington was established and has since decided to create a voluntary Housing Association to assist those for whom housing accommodation is an urgent necessity not necessarily because they are homeless, but because the unsatisfactory nature of the conditions under which they are living is causing hardship.

Mr. M. Ruddick, Senior Welfare Officer writes:—

"In conjunction with the District Councils an early warning system has been devised and this coupled with the continuance of the rent guarantee scheme lays down the brief of the protective work now undertaken by the social workers. Very often the social workers find themselves in the role of rent collectors and in this their frustration is hardly dissipated by the reluctance of the Department of Health and Social Security to pay rent direct to the housing authority.

Homelessness remains at a low incidence but nonetheless frequently presents an intractable problem to the field worker. The securing of alternative accommodation can be a difficult task in itself but the next move to satisfactory housing of a permanent nature can be even more difficult and hence "squatting" often results.

To ensure that homelessness is kept to a minimum the co-operation of many social work agencies may be necessary. The Seebohn Committee saw advantages in housing departments assuming responsibility for providing accommodation for homeless families. Unfortunately it seems that this recommendation may not be implemented, a fact which many social workers will regret since they feel such a provision would make rehabilitaton easier."

Registered Homes

There are three Homes for disabled or elderly persons registered by the County Council under Section 37 of the National Assistance Act, 1948. These are:—

Scalesceugh Hall, nr. Carlisle	—	30 residents
Rothersyke, Egremont	—	20 residents
Spring Bank, Braithwaite	—	10 residents

As registered Homes these are regularly inspected by my area staff. Scalesceugh Hall is run by the Cumberland, Westmorland and Furness Spastics Society for adult spastics. Rothersyke and Spring Bank on the other hand, provide accommodation and care for the elderly.

During this year an application was received for the registration as a private Home for the elderly of Salutation House, Heads Nook, Carlisle. In January 1970 the necessary fire prevention arrangements were completed and the Home has been registered to provide accommodation for six elderly persons.

As previously mentioned in the section Residential Accommodation for the Elderly, the adapted premises, The Croft, Kirksanton, were closed as a Home for the elderly on the 10th September, 1969. At the time of writing the Council has accepted an offer to purchase the property subject to a two year's lease prior to purchase and the premises were registered (as from 20th April, 1970) as a private home for the care of a maximum of 19 elderly persons.

The matrons of these homes are invited to appropriate staff meetings.

In view of the increasing demand for residential accommodation and the indications that there are many people who could afford private accommodation, the facilities provided by private Homes for the elderly form a valuable contribution to the total range of residential services for the elderly. This contribution is more valuable since this authority's Scheme under Section 21 of the National Assistance Act, 1948, was amended during 1969, to extend the powers of the local authority to making arrangements for the accommodation in privately run Homes for persons in need of care and attention.

Supported Independency Schemes

Since 1960 the provision of special housing for the elderly by County District Councils with financial support given by the Health and Welfare Committee has been a notable development and has provided a valuable contribution to our objective to organise supportive services which, supplementing that of relatives

and friends, enables the elderly to live out their lives in comfort and security without leaving the community.

Elderly people may need special housing because of a number of factors which include—the under-occupancy of the family home, the general inconvenience of the family home, or the need to have housing accommodation designed to meet their physical needs. Supported independency schemes not only provide accommodation to meet these factors, they also provide a warden service to give added support and security. The warden service is not intended to be a direct service to tenants, but rather that the warden should be a means of calling in appropriate domiciliary services from other sources and agencies.

The success of today's geriatric hospital services increases problems by restoring to partial activity many patients who formerly would have been chronic invalids in hospitals. Likewise the existing community services in their many forms ultimately create a need for residential accommodation. This is due to the fact that without these domiciliary services many elderly people would die or be taken into hospital. It is apparent, therefore, that the need for more residential accommodation increases rather than decreases in the long term as the domiciliary services, including supported independency schemes, are developed. New admissions to residential accommodation today have a degree of frailty which prevents their continuing to live in the community in spite of all the supportive community services.

The development of the provision of supported independency schemes has not been as rapid as I would have liked. 386 places by 1971 for elderly persons in Supported Independency Schemes will be provided in Cumberland. This is only 12.8 places per 1,000 of the population over 65 years of age compared with the estimated national norm for 1971 of 24.6. It should, however, be remembered that Cumberland's needs may well be below the national average because this is a predominantly rural area where the influences of the extended family socialogical pattern is much more in evidence.

Every endeavour has been made to persuade the housing authorities to increase their provision of supported housing schemes

for the elderly, and indeed, all but one of the County District Councils have at least one such scheme in operation or in process of development. Meetings were held frequently with the remaining authority (Whitehaven Borough Council) and I am pleased to record that the many difficulties of location have at last been resolved and a site has been allocated.

Only one new scheme came into operation during 1969—at Millom where a scheme for 12 persons in 10 flatlets is associated with the new residential home for 25 residents.

The following table lists the schemes at the 31st December, 1969, and includes the schemes to be completed within the next three years:—

Name of Scheme	District Council	Units	Places
Derwent Close, Keswick	Keswick Urban District Council	20	20
*Western Bank, Wigton	Wigton Rural District Council	20	40
Barras House, Dalston	Border Rural District Council	24	28
*Castle Gardens, Papcastle	Cockermouth Rural District Council	15	19
West Hill House, Brampton	Border Rural District Council	20	24
†Grisedale Croft, Alston	Alston with Garrigill Rural District Council	12	14
Manor Court, Cockermouth	Cockermouth Urban District Council	21	25
Brackenber Court, Penrith	Penrith Urban District Council	20	24
St. Michael's Court, Workington	Workington Borough Council	24	24
Wyndham Court, Cleator Moor	Ennerdale Rural District Council	22	24
†*Park Lodge, Aspatria	Wigton Rural District Council	10	20
Robert Rattrie House, Maryport	Maryport Urban District Council	20	24
†Lapstone House, Millom	Millom Rural District Council	10	12
		238	298

Available 1970				
Workington	Workington Borough Council	20	24	
		258		322
Available 1971				
*Silloth	Wigton Rural District Council	20	40	
Egremont	Ennerdale Rural District Council	24	24	
		302		386
Available 1972				
Stainton	Penrith Rural District Council	18	28	
Penrith	Penrith Urban District Council	20	24	
Mirehouse	Whitehaven Borough Council	20	24	
		360		462

* Bungalow type scheme.

† In association with an Old Peoples Home.

Following the guidance given by the Ministry of Housing and Local Government in their circular "Housing Standards and Costs—Accommodation Specially Designed for Old People" which was issued in October, 1969, it was decided to survey the bathing facilities in the existing schemes. These vary from individual bathrooms to bathrooms shared between three tenants. It was found that bathing practice ranged in the various schemes from less than 10% to 90% who took regular baths. It is interesting to note that no evidence was forthcoming that the sharing of a bathroom influenced the frequency of bathing. The services of a nurse or bathing attendant have always been available where this is requested—efforts are being made to stimulate a greater utilisation of this service since the reasons put forward for infrequent bathing have included the fear of not being able to get out of the bath.

HANDICAPPED PERSONS

The number of persons registered with this authority because of a permanent and substantial physical handicap, has further in-

creased during 1969. The following table illustrates how the numbers registered have increased over the past seven years:—

1963	...	...	...	278
1964	...	...	...	342
1965	...	...	...	415
1966	...	...	...	522
1967	...	...	...	614
1968	...	...	...	689
1969	...	...	...	735

The range of services offered to the registered physically handicapped is wide and varied and includes social clubs, craft classes, the supply of aids, gadgets and appliances, and adaptations to houses, etc. yet the incentive for all physically handicapped persons to register with the authority is not great. At present it is impossible to estimate accurately the number of persons in the county who suffer from "substantial and permanent handicap" but, largely resulting from the combined efforts of the family health care teams, this register is becoming more realistic. There were 103 handicapped persons who came on to the register during 1969 and of these 43 were 65 years of age or over. At the end of the year 266 of the 735 handicapped persons on the total register were in this age group. It is significant that 238, approximately one third of the total, were suffering from organic nervous disorders.

Two full-time centres are made available by the authority for all forms of handicapped persons—a purpose built centre at Workington and the other at Whitehaven in adapted premises. Eight other centres are used on a part-time basis according to local need, and 198 handicapped persons regularly attend these centres where they enjoy companionship which would otherwise be denied them. These centres are used also by persons suffering from other disabilities such as blindness and deafness and where practical there is an integration between the groups. In the main, therefore, these centres are staffed by my social workers and home teachers of the blind with the support and assistance of an occupational therapist, coupled with an invaluable contribution by voluntary effort. Without the time and energy so willingly given

by voluntary sources, the present level of social and recreational facilities could not have been achieved. The value of these clubs in providing a useful and acceptable point of contact with other welfare services and voluntary agencies cannot be over emphasised.

As previously mentioned in the section of this report "Prevention of Illness, Care and After-Care" members of the Cumberland Branch of the British Red Cross Society act as agents for this department for the issue, on short loan of aids, gadgets and appliances to the severely disabled who need them as substitutes for their physical deficiences. Where these aids and appliances are required on a long term loan their issue is undertaken by the Department of Health and Social Security via the family doctor and hospital consultant.

In many cases loan equipment is provided until the equipment supplied by the Department of Health and Social Security is available.

Adaptations to disabled person's houses to increase their independence, comfort and convenience are arranged by my department and include such items as handrails, the widening of doors, ramps and bases for the garages to house the special vehicles supplied to the disabled. Many of the County District Councils (as housing authorities) now meet the cost of these adaptations in their own properties, but the cost to this authority n adaptations to non-council houses has more than doubled during the past two years. Comparatively minor works which cost relatively small amounts can be of tremendous benefit to the daily living of a physically handicapped person and this, with the expertise which is increasingly available to pinpoint the need for these aids has prompted my Committee to increase still further its budget provision for this purpose.

Special Car badges are issued under a scheme introduced by the Ministry of Transport and the Department of Health, to assist severely disabled drivers to overcome their parking problems. These badges have been issued to 86 disabled drivers which represents an increase of 27 in the last two years, following extensive publicity given to the scheme through the goodwill of local newspapers.

Holidays for the Disabled

For some years the Committee was pleased to offer financial assistance to the Cumberland Council of Social Service in their arrangements for providing holdays for disabled persons but owing to the very difficult economic climate, this assistance had to be refused for the second consecutive year. I am happy to report, however, that the Cumberland Council of Social Service raised £600 by voluntary efforts and Mr. R. Mulelly Secretary of the Cumberland Council of Social Service reports:—

> "In 1969 a party of 65 handicapped people, their escorts and helpers enjoyed a week's holiday in North Wales. The Council has a close working arrangement with the County Council's Welfare Officers as regards the arrangements for the holiday whilst the skilled and devoted assistance of members of the British Red Cross Society, the St. John's Ambulance Brigade and the International Voluntary Service is deeply appreciated".

Blind and Partially Sighted Persons

The following table shows the age groups of blind and partially sighted persons registered on 31st December, 1969:—

		Blind			Partially Sighted		
Age Group		**M.**	**F.**	**Total**	**M.**	**F.**	**Total**
0—1	...	—	—	—	—	—	—
2—4	...	2	—	2	—	—	—
5—15	...	3	—	3	10	4	14
16—20	...	—	2	2	6	3	9
21—49	...	29	15	44	17	14	31
50—64	...	28	34	62	13	13	26
65 and over	...	128	230	358	36	61	97
TOTAL	...	190	281	471	82	95	177

The number of blind persons decreased by 10, and of partially sighted increased by 8 during the year. 47 blind and 26 partially sighted persons were registered during the twelve month period. From the table it will be seen that 76% of the blind and 55% of the partially sighted are over sixty-five years of age.

The supportive services for blind and partially sighted per-

sons in Cumberland continued during 1969, to be organised and run by 4 qualified home teachers of the blind. It has proved to be impossible to recruit an additional qualified home teacher.

The 4 teachers cover the administrative county with the exception of South Cumberland with support given by the other 16 social welfare officers. The Barrow, Furness and South Cumberland Society continues to act as agent for the Council in the provision of Welfare services for the blind and partially sighted in the southern part of the county. Towards the end of this year the visiting service undertaken by their home teacher was increased to one full day per week.

Recreational and craft clubs for the blind are now held at 15 centres throughout the county and are regularly attended by 193 blind and partially sighted members under the supervision of the home teachers of the blind often with the help of social welfare officers.

Miss M. Shuttleworth, Home Teacher of the blind, reports on a new venture for blind persons, thus:—

> "This was the first year that a combined group of persons, approximately 46 (blind, physically handicapped and psychiatric after-care) went on holiday together from Princess Street Social Centre, Workington.
>
> May of this year saw a coach-load of people accompanied variously, by guide dogs, walking aids, and wheelchairs, make the journey to Southport, for a week's holiday at a first class hotel on the promenade.
>
> A marvellous time was had by all, the weather was kind, folks mingled together really well. We took coach trips to numerous places of interest in the vicinity, and took advantage of the grand shopping facilities; the week culminated in an absolutely super 'Last Night Party' provided by the hotel proprietors and staff.
>
> Indeed this venture proved so successful that a second group, similar in size went along in September to the same venue, where once again all the amenities were enjoyed to the full, in fact there was so much this second group wished to see and do, that 4 extra wheelchairs were borrowed from

Southport St. John's Ambulance Brigade.

On both these holidays we had ninety year olds—one registered blind and the other handicapped. (Each morning after breakfast was surgery time, when dressings, etc., were renewed, other first aid being rendered as and when necessary).

Participants on these holidays were from Carlisle, Maryport, Clifton, Cockermouth, Keswick and Workington.

Special thanks are due to Distington Ambulance personnel who brought a number of the folks to and from the centre, prior to and following their holiday, and to the coach driver employed by the private hire company, whose main interest was the comfort of his passengers.

A most successful venture, which one hopes can be repeated annually".

Miss L. Fraser, Home Teacher for the Blind comments:—

"A new model of talking book machine has been introduced. This is smaller and takes a smaller type tape cassette which is much more convenient for posting. The existing machines are gradually being converted to take this smaller tape cassette. The quality of reproduction has been much improved recently, and this has been much appreciated by the blind and has given added enjoyment to their 'reading'. The delay in supplying a talking book machine is now about three months after the home teacher has completed the form of application. The range of 'books' is now extensive and most can be obtained by return of post.

Radio sets too follow the popular trend with the issue of V.H.F. transistor sets instead of mains operated radios by the British Wireless for the Blind Fund.

Members of the social and craft clubs at Penrith and Alston entered handicraft competitions organised by the Cumberland Show and the Penrith Agricultural Society Show, and derived a great deal of pleasure and encouragement from their success in these competitions".

Training of Blind Persons—Long Cane Technique

The value of the long cane technique for certain blind persons is apparent to me, and much thought has been given to this subject. It is obvious that there are two alternative means by

which training can be achieved. The blind person could be sent for a course in social rehabilitation which would include (where appropriate) training in the long cane method, but this could cost in excess of £300 for each individual's attendance at an appropriate course and could cause domestic difficulties because of the length of the training period (10 to 12 weeks). The other approach is to train one of the home teachers of the blind as an instructor in the long cane method, who would then return to the county and be available for teaching suitable blind people throughout the county. It has been agreed that the latter method will be the most rewarding and plans are being made for one of the home teachers to attend such a course.

Workshops for the Blind

The Joint Sub-Committees of the Councils of the City of Carlisle and this county which undertook the administration of the Cumberland and Carlisle Workshops for the Blind at Harraby, Carlisle, from the voluntary organisation in 1962, have striven to modernise the workshops and transform them from a traditional craft work centre to a modern industrial factory. This has been a gradual and continuing process. At that time the workshops consisted of two large work buildings: one had been adapted from an old coach house, the other was purpose-built in 1957. The adapted premises were closed in 1966. The blind and disabled workers have been gradually withdrawn from traditional craft work trades and retrained in skilled industrial processes. Only two of the blind workers continue to do craft work, namely rush seating and cane chair making, otherwise production is now confined to the manufacture of brushes, divans, mattresses, cushions and upholstery products.

In 1968, following consultations with the Industrial Advisers to the Blind Limited, plans were formulated to convert the work area from a series of small rooms into a spacious open plan workshop by the removal of internal partitions. Coupled with this an 800 square foot extension was planned to accommodate the bed mattress teasing room, thus removing a rather dusty operation from the main workshop area. Without greatly upsetting the production these plans were implemented during 1969, and the work areas have now been set out on production line

principles, thus minimising the degree of handling of both raw materials and goods during producton.

The national tendency is for workshops for the blind to group together in each area to form more viable units. This has been considered in some depth at the meetings with the Industrial Advisers to the Blind Limited, but it has been decided that owing to the relative isolation of the Carlisle Workshops a grouping with other Workshops for the Blind is not feasible. Co-operation with other handicapped centres in the area, however, has also been considered and this has resulted in the closing down of the divan frame making section and purchasing these frames from the Kingstown Adult Training Centre, (for subnormals) Carlisle. The closure of this section affected the employment of one able bodied sighted employee. Similarly it has been decided that at present the Carlisle workshops will not participate in the central sales service that is shortly to be operated by the National Association for Workshops for the Blind in conjunction with the Industrial Advisers to the Blind Limited. This decision was taken in the light of the present success of Major Holt, the Workshops Manager, in finding adequate sales outlets locally.

The following table shows the trend to workshop production (as measured by sales) over the period since 1963:—

Year		Sales	Number of Employees (including trainees)
1963	...	£18,967	30
1964	...	£24,023	33
1965	...	£30,219	37
1966	...	£34,368	32
1967	...	£35,693	33
1968	...	£39,030	32
1969	...	£37,589	33

The slight fall in sales during 1969 I am pleased to say was accompanied by a reduction in the production loss per approved worker which now compares very favourably with the national average for similar workshops. In an endeavour to increase to overall efficiency of these workshops a continuing analysis of the productivity and profitability of each section is maintained. Resulting from this there has been a gradual run

down of the brush making section and the transfer of the workers to the bedding and upholstery section which are more profitable. The indications are that the brush making section will be closed completely within the next eighteen months to two years.

The national decline in the incidence of blindness coupled with the greatly improved facilities for training blind persons to take their place in open industry have led to a gradual change durng the past decade in the role of workshops for the blind. Previously these workshops only employed blind and partially sighted persons, whereas to-day they have become sheltered workshops for disabled persons generally. This trend has been reflected at Carlisle. Only three blind persons have been admitted for training during the past six years, whereas sixteen physically and/or psychiatrically handicapped persons have been admitted. The ratio of blind and partially sighted to other classes of handicap employed at these workshops has changed from 9 to 1, to 2 to 1 over these six years.

In conjunction with officers from the Disabled Persons' Branch of the Department of Employment and Productivity it was agreed last year that, for an experimental period suitable psychiatrically disabled persons from Carlisle and surrounding area be admitted to the workshops for training on the authority of the local Group Disablement Resettlement Officer and the appropriate City or County Council. In this way rather complex Department of Employment and Productivity admission procedures were overcome, thus reducing the period before an admission is approved. During 1969, the first year of this experimental period 7 psychiatrically disabled persons were admitted for training at the workshops. Of these 1 successfully completed the course of training and is now an approved worker, 2 are still under training and the remaining 4 failed to satisfy the minimum standards or because they became medically unfit.

Major C. W. Holt, Manager of the Workshops reports:—

"Close co-operation is still being maintained between the management and employees to improve the working conditions and general welfare. The recent major changes in the workshops layout have been the subject of discussions with the employees throughout.

Visits have been made to other workshops by myself

and other selected employees to maintain a constant liaison on new developments.

The sales trend during the year was comparable with the previous years, but showed a marked increase in the more profitable areas of activity such as upholstery.

Examination of the accounts revealed a fall off in sales in the Brush Department. This was due to the completion of a contract with a motorway contractor and the Brush Department is being steadily reduced in manpower.

The first results of the project for the introduction of mentally disabled persons have been most encouraging.

The workshops are frequently visited by the general public who have shown a keen interest in our work, and I would like to thank all visitors for their continued interest and everyone who has supported us by purchasing our products".

Blind Home Workers

Last year I made reference to a young man of twenty-five years who with the advice of the Department of Employment and Productivity specialist officer and the commendable support from his family had established his own pet food shop business. I am pleased to state that based on the six month period ending the 31st March, 1969, his trading profits were such that he qualified for augmentation under the Blind Home Workers Scheme.

There are two other Cumbrians who participate in this scheme. One has been self-employed as a pig keeper since 1962. His trading profits this year had dropped dramatically due to an infection which resulted in the death of 22 pigs. Despite this his average weekly profit over the last three years was more than double the qualifying rate. The other has been an approved blind home worker since the inception of the scheme in 1953. His small holding trading profits over the past three years did not reach the qualifying minimum figure. In the early part of this year a Ministry of Agriculture and Fisheries specialist officer, advised on how this small holding might be run so as to provide a reasonable financial return, but the blind home worker felt unable to accept these recommendations on account of his lack of capital. My Committee, however, agreed to pay maximum augmentation for a further year.

Sheltered Employment

The only provision of sheltered employment and training for such employment by this authority, under Section 3 of the Disabled Persons' Employment Act, 1958, is limited at present to the 12 sighted disabled persons who are authorised by the Department of Employment and Productivity at the Workshops for the Blind, Carlisle. Whilst I have been concerned regarding the underprovision of sheltered employment facilities in Cumberland for some years the recent financial restrictions have forced me to defer the provisional 50 place sheltered workshop at Lillyhall Estate from the Capital Development Programme for 1970/71 to 1971/72.

Deaf and Hard of Hearing

The welfare service for the profoundly deaf has continued to be provided by the Carlisle Diocesan Association for the Deaf who act as agent for the County Council.

The area of operation of the Association consists of the counties of Cumberland and Westmorland, the Furness area of Lancashire, the County Borough of Barrow in Furness, and the City of Carlisle. The cost of this provision is borne by the local authorities on a per capita basis.

The register of the profoundly deaf has been very realistic for some years and therefore varies little from year to year. At the 31st December, 1969, in the administrative county, 32 deaf persons with speech and 73 deaf persons without speech were registered.

Mr. J. M. Barber, Secretary/Superintendent of the Association comments:—

> "The present staff of the Association consists of 4 social workers, including a trainee, who was appointed in September, 1969. He is the son of deaf parents, and has already proved his aptitude for this type of work. They are all mobile and are not restricted to a specific area. This is of great benefit to the deaf as it means that in times of staff illness, holidays, etc., there is always someone available who is known by the deaf, and this banishes any reluctance or fear that may be there.

Routine visiting is maintained, and particular attention is paid to the elderly, the sick, and the hospitalised. In the case of the latter, visits are made three or four times per week. A deaf person can feel very lonely even in a ward full of people. Help has also been given to hard of hearing people in the way of hearing aid counselling. Many of these people are bewildered at the amount of literature available about aids, and in a few cases they have been badgered by salesmen. There is very good liaison with the Hearing Aid Departments at the Cumberland Infirmary and West Cumberland Hospital. Many deaf people show an interest in the "flashing light" door-bell and help has been given regarding this aid.

There has been the usual help with visits to doctors, hospitals, dentists, solicitors, etc., plus assistance with form filling for income tax, Social Security benefits, housing, etc.

Much time was spent with one deaf man who was knocked down by a motor cycle and then sued by the rider, and after two years the case was finally heard. The judge dismissed the case and awarded costs to the deaf man, and whilst the verdict was pleasing, the deaf man and his wife had suffered two anxious years.

There has been the usual social events, bingo, whist, egg dumping, etc., plus inter-club activities between deaf members from other parts of the country. Outings to places of interest have been arranged, plus outings to events organised by the British Deaf and Dumb Association. A coach-load of deaf from West Cumberland attended a rally held at Tynemouth, where over 500 deaf from the north attended.

Arrangements were made for the Northern Gas Board officers to speak to groups of deaf about conversion to North Sea Gas.

Spiritual welfare still plays an important part in the life of a deaf community. Religious services are regularly held at all centres, including West Cumberland and, thanks should be given to the Reverend N. Dixon of Holy Trinity with Christ Church, Whitehaven, for allowing the deaf the use of the Church for Holy Communion, and celebrating it on their behalf.

The Bishop of Carlisle attended the Carlisle Chapel and gave the sermon at Evensong. Deaf people from all over the area attended.

In August, 1969, a Communal Service was held at Patterdale on Ephphatha Sunday; about 100 deaf from all over the Diocese attended the service was followed by tea, and then a trip on one of the steamers on Ullswater.

It becomes increasingly difficult to obtain decent jobs for deaf people, whether school leavers, or adults. There is very good liaison between the Association and the Disablement Resettlement Officer and the Youth Employment Officer, but in many cases it is easier for the Welfare Officer to obtain work for a deaf person, as he has a more intimate knowledge of his capabilities, and in many, or rather, most cases, the first person to know if a person is out of work is the Welfare Officer of the deaf.

The social recreation centres for the deaf are very well attended by the young and old alike and at the same time. These centres for the deaf still prove to be the hub of the Community and is still a clearing house for a host of problems, whether large or small, serious or laughable, spiritual or social. Someone once said 'If the need is there, let it be met.'. The need is there and it is being met."

My own social work staff naturally look to their colleagues in the Diocesan Association as being the expert case-workers amongst the deaf in the community. In cases of multiple handicap, including deafness, it is gratifying to note the co-operation and mutual support which exists between the county social welfare officers and the Association's welfare officers. I am happy to say a similar degree of liaison and co-operation exists with the Education Departments peripatetic teachers of the deaf.

The number of persons registered as being hard of hearing has climbed but slowly during recent years, the total at the end of 1969 being 144. Despite efforts by my officers to organise social and other club activities for this group of disabled persons, the conclusions reached are that because of the acceptance of this disability by the community at large, and the fact that those who are hard of hearing tend to be well integrated in the community with a normal range of interests and activities, special facilities are not in demand. Probably the most fruitful assistance which

could be offered would be in relation to initial guidance in the use of hearing aids and instructions in their care and effective maintenance.

Day Centres, Luncheon Clubs and Meals on Wheels

The value of these supportive services in maintaining the elderly in the community cannot be overstated.

Day Care

There are no self-contained day care centres in Cumberland. In part this is due to the geography of the county with vast sparsely populated areas but the major reasoning behind this lack of service is the concentration in the capital development programme of small neighbourhood care Homes for the elderly. Each Home now being built makes provision for "at risk" elderly requiring day care. This facility is being provided in such a way that these can either be integrated with or segregated from the residents as local circumstances dictate; in this way, the privacy of the residents can be respected. The experience in this authority is that these "visitors" are generally welcomed by the residents for the local news which they bring into the Home.

The scale of day care provision is relatively small since only nine Homes for the elderly at present offer this provision to an average of 36 persons. Whilst only an additional 4 persons on average receive this service as compared with 1968, the number of days per week each person attended during 1969 showed an increase. It is confidently expected that there will be an increased provision of about 25% annually as more Homes become available which are designed to cater for day visitors.

Since this service can only be offered to those elderly who are considered to be "at risk", selection is of paramount importance and this is undertaken by the social worker in close consultation with his colleagues in the family health care team and/or hospital medical and nursing staffs. In many cases day care for as little as one or two days a week can so influence the individual circumstances that the necessity for full residential care is greatly reduced and may even be eliminated.

Luncheon Clubs

Of the seventeen luncheon clubs throughout the county the Cumberland Old People's Welfare Committee organise seven, the

Women's Royal Voluntary Service four and the remaining six are run by the matrons of Old People's Homes; a total of 331 persons regularly attended these luncheon clubs during 1969, an increase of 38% as compared with 1968.

The Old People's Welfare Committee luncheon club at the Old Custom House, Whitehaven had their meals delivered from the Old People's Home, "Garlieston", Whitehaven until August, 1969. After extensions to their kitchen at the Old Custom House some of the more active members now prepare and cook the meals on the premises. This club is now open on five days each week and on average 133 three course luncheons are served weekly.

Accommodation difficulties necessitated the closure of the Frizington Club early in the year. I am glad to report that new accommodation was found at the Veterans Club Hall and that the club re-opened in November, 1969, the 26 meals being supplied weekly from the Old Custom House Club at Whitehaven.

Meals on Wheels

This service which is provided on an agency basis by the Women's Royal Voluntary Service has developed rapidly over the past ten years from a figure of 300 meals delivered in 1959 to 58,766 in 1969. The year 1969 has shown a 10% increase in the number of meals delivered as compared with 1968. Almost 600 elderly persons throughout the county are now receiving this service from over 500 Women's Royal Voluntary Service members who give so unstintingly of their time and energy. Of the meals delivered in this county the School Meals Service and Old People's Homes each supply about a third and the balance are supplied by hospital kitchens, factory canteens and local inns. The cost of each meal to the recipients has been maintained at 1/3d. The transport costs in the delivery of these meals are met by the County District Councils who have equal statutory powers with the County Council to provide this service.

To date the practice has been to provide each recipient with two hot meals each week but the aim for the future is that the service will have three main functions.

1. For the sick or mentally confused or physically infirm elderly who live alone, the service will aim to provide a significant contribution to their nutrition. To do this it will be necessary to provide for this group a daily service.

2. A relief function to provide meals on two or more days each week to enable caring relatives, friends or neighbours to have some degree of freedom from their responsibilities.

3. A purely temporary function to provide a service for elderly persons for the period after discharge from hospital or whilst caring relatives are on holiday, etc. The frequency of delivery for this group will depend upon the individual circumstances.

All of this is against a background of increasingly sophisticated development of screening and assessment of the needs of the elderly in the community. Referrals for this service come to the Women's Royal Voluntary Service from many quarters, but these are then assessed by the community nursing staff. This contributes to a standardisation of qualification for the service, as well as to a wider pattern of community care in which the nursing staff are often already involved. The value of the role of the home help in the provision of meals for the elderly is clearly important and a survey is soon to be undertaken to assess this contribution.

To implement these changing aims heavy demands will be made on financial resources, manpower, kitchen facilities and transport. It is estimated that the present financial expenditure will be more than doubled. The Women's Royal Voluntary Service consider that their present membership could extend their commitment by about 25%, but beyond this their membership would have to be increased. The Department of Health and Social Security limited the number of meals which each Home for the elderly could supply each day for this service to 30% of the number of residents accommodated. This limit has recently been increased and each Home can now supply meals up to a total equivalent to the number of residents in the Home but to achieve this additional kitchen equipment and staff will be required. It may ultimately be necessary to provide kitchens in parts of the county specifically for the Meals on Wheels Service. It is also anticipated that there will be marked developments in the principle of a "good neighbour" meals service and luncheon clubs. A single meal prepared by a neighbour has all the advantages of home cooking for individual tastes and while this may be more difficult to organise and control it has much to commend it. The luncheon clubs provide a valuable companionship component for those able to attend.

The International Voluntary Service, Whitehaven branch, started a pilot scheme in 1969 whereby eleven elderly residents in Whitehaven who had been receiving Meals on Wheels twice weekly, now have a hot meal delivered to their homes each Saturday. This additional meal has been much appreciated by the recipients and the indications are that this new service will be extended to other urban areas. In July the Women's Royal Voluntary Service who act as the Council's agents for the service started a trial scheme using quick frozen prepared meals for the Meals on Wheels and the Lunch Club in Egremont. The trial scheme was so well received that the monies raised by the local Rotary Club, Wyndham School Jumble Sales and the "Friends of the Women's Royal Voluntary Service" enabled the Women's Royal Voluntary Service to purchase two special hot air circulation ovens and two large deep freeze units. An analysis of the quick frozen prepared meals served at Egremont indicate that the protein content is adequate. A good variety of dishes is available and the old people thoroughly approve of this type of meal. Some of the benefits of using quick frozen prepared meals are:—

1. There is no food preparation.
2. Skilled cooks are not required.
3. There is no washing up.
4. Time is saved.

Consideration has recently been given to the possibility of providing an evening meal delivery service for some of the elderly in Cumberland. The initial reaction is that it would be difficult to implement, mainly as the delivery timing coincides with the period of the day when few voluntary workers are available—the Women's Royal Voluntary Service members are at home preparing their family meal and the teenagers are busy with their school studies at home. Further enquiries into this, however, are continuing.

Staffing and Training

(a) Social Welfare Officers

It was in the late 1950's that this Council accepted the principle of secondment to approved courses of training as a means of ensuring, in the long term, that adequately trained field workers would be available to meet the ever increasing demand for their

services. Cumberland has been making a generous contribution to the general pool of training in the expectation that some officers trained at the Council's expense would in due course move elsewhere to widen their experience but equally it was expected that adequately trained staff would be available in increasing numbers and that some would seek appointments with this authority. In the absence of any "pooling" arrangements some authorities have been unwilling to involve themselves in the cost of training. In this unbalanced situation this department has tended to lose trained officers on promotion to other authorities without recruiting trained replacements. There has in fact been a drain of 50% of the trained staff over the year.

This year one officer successfully completed a one year full time course at Newcastle Municipal College of Commerce for experienced social workers. Three qualified social welfare officers left the department during 1969: a senior social welfare officer went to another authority as a trained officer and the other two transferred to the Children's Department. Of the three social welfare officers recruited to the service during the year, two are registered mental nurses.

The University of Newcastle Department of Adult Education organised a refresher course for social caseworkers at Herbert Atkinson House, Carlisle, commencing in February, 1969. This course was held each Thursday afternoon and evening for six consecutive weeks and was attended by probation officers, social welfare officers, child care officers from the City of Carlisle and this authority. Six officers from this authority attended this course. Apart from the value of the theoretical aspects of this course the officers attending greatly appreciated the discussions with other related disciplines.

The social welfare officers fill a dual capacity in that they are also statutorily appointed to undertake social work duties deriving from mental health legislation. The overall positon is satisfactory in that there are no vacancies on the establishment.

(b) **Residential Staffs:—**

Within the restrictions which are imposed by the finance available and the paucity of training facilities in residential care, there has been an active policy of secondment to appropriate

courses. Since 1961, 7 matrons have attended the 14 week residential courses organised by the National Old People's Welfare Council and 30 matrons and assistant matrons have attended one week residential "Refresher" or "Special Emphasis" courses organised by the same Council.

In the report by the Committee under the Chairmanship of Lady Williams it was stated that adequate staffing of residential establishments in the future could not be hoped for without the promotion of more comprehensive training facilities leading to a definite career structure. This was followed by an announcement in January, 1969, by the Council for Training in Social Work that they had accepted the invitation from the Department of Health and Social Security to extend its responsibilities to include training for residential work in the health and welfare field, and that it would be promoting both qualifying courses and a scheme of in-service training. No long term training courses were organised by the National Old People's Welfare Council during 1969. One week "Special Emphasis" and "Refresher" courses were still held and six matrons and assistant matrons from this department were seconded to these courses. It is planned that at least one matron will be seconded by this authority to attend the first one year residential care course promoted by the Council for Training in Social Work.

During 1965, a trainee scheme in preparation for appointment to senior posts in the residential homes for the elderly was introduced and it was encouraging to learn that the William's Committee report made very similar recommendations aiming towards a recognised national qualification and a progressive career structure. The local scheme has had a limited success. Since the scheme started nine trainees have been appointed. Of these three have progressed sufficiently in their training to merit promotion to assistant matrons posts, three have resigned and three remain in training. Approval has been given by my Committee to increase the establishment of trainees from four to six in 1970.

(c) **Wardens of Supported Independency Schemes**

Short courses of training for wardens are available nationally through such agencies as the National Old People's Welfare Council but as these are residential courses it has in the past proved difficult for the District Councils who employ these wardens, to have them seconded. In the interest of the service I organised

such a course at Carlisle and it was held each Wednesday for nine consecutive weeks commencing 5th March, 1969. Without exception the District Councils who operate supported independenc scheme in the administrative county agreed to send their wardens within the limitation of the time available. A comprehensive programme included lectures from a consultant geriatrican, a fire prevention officer, the welfare organiser from the Cumberland Council of Social Service, a housing officer from a District Council and medical, together with nursing and welfare staff from this authority. The success of this course was marked and no doubt a "follow-up" course will be organised along similar lines.

(d) **Police Cadets**

This scheme which started experimentally in 1967 to accept police cadets during their final year of training to give practical experience in the field of human relationships proved so successful in the past two years that another young cadet was seconded to this department commencing 13th January, 1969, for two periods of four weeks with a two week break between these periods. His programme was designed to present every opportunity for active participation in work involving personal contact with the handicapped, inadequate and elderly in the community.

(e) **Other forms of training**

The conversion of gas appliances throughout Cumberland by the Northern Gas Board commenced early in 1969 with a planned programme to continue into 1970. Whilst the publicity regarding this conversion was the responsibility of the Northern Gas Board, it was considered that this department had a role to play especially with the handicapped and the elderly in the community who are visited by nurses, health visitors, social workers and voluntary workers. Lectures were arranged for these groups in each of the three administrative areas by the Public Relations Officer (Conversion) of the Northern Gas Board.

I feel that it is incumbent upon the department to offer the opportunity for students to pursue their studies in the practical situation during their vacations with experienced and trained officers available to devote time to this exercise. To this end a first year psychology student from Reading University spent five weeks in the Western area commencing August, 1969, observing the statutory functions of the health and welfare services.

MENTAL HEALTH

MENTAL HEALTH

The care of the mentally disordered in the community has continued to develop along the lines which have been adopted in Cumberland for other groups namely local authority staffs working in a team situation in the community through attachment to family doctor groups. This approach, in relation to social work support, tends to be a little more tenuous than in the nursing field, but to an increasing extent the social workers field of operation is being more closely identified with the group practices rather than the traditional geographical boundaries. Alongside this close association with the general practitioners, the links with the hospital and consultant service have been maintained and strengthened by regular meetings at case conferences with the consultants, the hospital nursing staffs, and the hospital based social workers.

From the training aspect, the emphasis has veered more in the direction of the adult subnormal in the community since the provision for juniors in Cumberland has reached a very satisfactory level.

All through the year an air of uncertainty has prevailed throughout the local mental health services because of impending changes in their structure and organisation, which are expected when decisions have been taken on the future pattern of the health services and the personal social services. In this climate of uncertainty forward planning tends to be more hesitant, a tendency that has been resisted. On the other hand I have been pleased to note an increasing public concern at the levels of service available to the mentally disordered—at least the anxieties which have been so volubly expressed through the mass media, both in relation to the hospital and local authority services reflect a welcome change in attitude and a growing acceptance of "care" for the mentally disordered by the community in general. Those responsible for these services have long recognised that the accumulating inadequacies are directly attributable to the simple fact that the mental health services have always been allocated finance at a comparatively low level. Adequate services can only be achieved when adequate resources (in buildings and manpower) are available One can only hope that those who felt it necessary to express their indignation at prevailing conditions will not raise an equal voice

if and when there is a call for additional finance to remedy the situation.

The following table summarises the statistical data in relation to the local mental health service over the last five years:—

Caseload at year end	1965	1966	1967	1968	1969
Mentally ill and psychopathic	396	447	452	431	438
Subnormal and severely subnormal	449	511	497	483	481
Elderly mentally infirm	—	62	54	75	92
	845	1,020	1,003	989	1,011
On training centre registers	135	162	168	174	190
Awaiting admission to training centres	39	3	10	5	5
In local health authority residential care	25	38	61	60	74
On hospital waiting lists (subnormals):—					
Urgent cases	1	—	—	—	7
Others	20	13	12	11	17
New cases referred:—					
Mentally ill and psychopathic	223	202	184	140	111
Subnormal and severely subnormal	62	70	40	37	62
	285	272	224	177	173
Number of social welfare officers	14	14	14	15	16

During the first seven years of operation of the Mental Health Act, 1959, the domiciliary caseload within the generic term "mentally disordered" more than doubled but the indications in the last three years have been towards a levelling off in the numbers coming within the two main groups of mental illness and mental subnormality. Beginning in 1966, statistics concerning the elderly mentally infirm were separately extracted to show those receiving services or accommodation provided under the National Health Service Act, 1946—those resident in welfare Homes for the elderly being specifically excluded. The identification of confused states amongst the elderly which require social and/or nursing support in the home is simplified as a result of the team approach but the mounting caseload in this category gives rise for concern. The prognosis in these cases is usually poor and the social pressures within the family increase as time goes by. Shortages in geriatric accommodation for long term care both in hospitals and welfare Homes provided as a relief service to relatives, make the task of the domiciliary services all the more difficult.

Training Centres for the Subnormal

(a) For Juniors.

The two purpose built junior centres at Hensingham and Wigton, providing 75 and 45 places respectively, continue to meet the need for the training of those children who are at present considered "unsuitable for education at school" on account of mental subnormality. This represents a ratio of 0.55 places per thousand population. This figure is marginally greater than the national forecast for the year 1976. With boarding facilities provided in this rural area for those children who live beyond a reasonable distance for daily travel to a training centre there has been virtually no waiting list for admission to the junior centres since 1966. By arrangement with the Carlisle City Council 4 juniors attend the City's Centre at Kingstown because their homes, whilst in the county area, are geographically nearer that centre.

At the end of the year there were 98 children attending the centres at Hensingham and Wigton (including 16 in the unit at Hensingham for those requiring "special care") so that, in effect, accommodation is available for at least a further 20 children. Total attendance at 14,431 in 1969 were slightly fewer than during the preceding year (14,564) see histogram on page 199, mainly because it became necessary to close the Hensingham Junior Training Centre prematurely for the summer holiday (on the 4th July) when one of the children was found to be suffering from sonnei dysentery. Eleven juniors left the centres during the year—4 on transfer to adult centres, 2 moved to another area, 1 was admitted to hospital because of a physical deterioration, 1 was excluded at the age of 16 as unsuitable for further training and 1 seventeen year old girl returned home without proceeding to further training. It is pleasing to record that 1 boy was transferred to the authority's residential special school for educationally subnormal pupils and that 1 little girl, after a period of stabilisation at the Hensingham Centre was able to be accepted at a local infants school.

There have been serious staffing problems at the Hensingham Junior Training Centre during 1969. I deeply regret the deaths, after long and painful illnesses of two most valued colleagues—Miss Love who was Supervisor since 1964 and Mrs. Martin whose nursing experience and devotion contributed so greatly to the success of Cumberland's first special care unit. It was necessary

to recruit temporary staff and there was inevitably periods of under-staffing. I am most grateful to the remaining staff for their willing acceptance of very difficult conditions and in particular to Mrs. Bowie who was later promoted to the senior post.

The announcement in November, 1968, that responsibility for the education of mentally handicapped children was to be transferred to the education authorities has caused anxieties to both parents and staff alike throughout the year. In the absence of more detailed information regarding the implementation of this policy, apprehension and speculation have been much in evidence and I have felt it incumbent upon me to try to maintain the morale of the staff engaged in junior training centres and to safeguard the goodwill of parents. In so doing I have tried to emphasise that, in the future, all children (including the mentally handicapped) will share the same basic right to education according to ability and that this in turn opens up new areas of scope for further development and progression to other forms of education. In discussions with the staff who remember the recommendations of the Scott Committee which were not implemented there was a great welcome for the prospect of improved facilities for the training of teachers and the opportunity to benefit from closer association and training with other teachers. For many years they have recognised that the needs of their charges are for "education" as distinct from "training or occupation" and that the existing pattern of their own training no longer measures up to th erequirements of their pupils. One result of these uncertainties has been the development of closer and more fruitful relationships with parent groups. In meetings with these groups they have been invited to discuss their anxieties and I feel sure that, in addition to relieving many of their worries, they now enjoy a more positive involvement in the pattern of future policy for the education of their handicapped children. They have all suffered the traumatic experience of the formal "recording" of their child as "incapable of receiving education at school" and they welcome the proposal to bring to an end the present system of exclusion from school. There remains, however, some degree of concern about those children whose disabilities are so severe, both mentally and physically, that the need for "care" as at present provided in special care units, seems to be of greater import than "education". I have expressed the opinion that the policy appears to me to be

directed towards the abolition of Section 57 of the Education Act, 1944, rather than a shift in the criteria for exclusion from the educational system to a lower level. So far as medical and nursing support is concerned I have stressed that the concept of "community care" as a continuing and comprehensive process.

I am grateful to the supervisors of the two junior centres for their comments as follows:—

Mrs. Bowie (Hensingham):

"The year's activities have been marred by serious staffing difficulties due to illness and I greatly appreciate the support which I have received, not only from the regular members of staff but also from those who came into the Centre to tide us over the more trying periods as a result of which steady progress has been maintained.

By arrangement with the Grammar School, there has been encouraging progress in swimming but the calls on the bath restrict our use of it to one session a week during which 12 to 14 of our children can be taken into the water. I am most grateful for the help given by the staff and senior boys of the Grammar School. The success of this experiment so far leads me to think that this development in training should be considerably extended in scope—even to the length of taking our special care children into the water for relaxation and as a therepeutic exercise.

I welcome the opportunity to express my thanks to the parents for their continuing support and encouragement and to the girls from the Grammar School for their regular and enthusiastic help during the free-play period which follows lunch each day."

Miss Lister (Wigton):

"The staff are naturally anxious about the future of our centre but in general they regard the proposal to transfer responsibility to the Education Department as being in the children's interests because of the promise it offers for them to participate in a wider spectrum of educational opportunities. During 1969 we have tried to enlarge the experience of our children, with the help of parents, by more venturesome outings—to Morecambe, to a zoo and to an aviary. The Wigton Centre is small and with the improvement of training facilities for young adults, our older children are able to move

on more easily at the appropriate stage of their training. We would all welcome the opportunity, if and when the occasion arises, to bring very young (under 5) trainable children into the Centre."

Special Care Units

Two separate units are provided for the day care of those subnormal children whose disabilities, frequently coupled with a severe physical handicap, are of a degree which prevents their participation in the normal training programme in junior centres. The Hensingham Junior Training Centre incorporates a unit for ten such children. The hostel for subnormal children at Orton Park is unoccupied during the day, whilst the boarders attend the Wigton Centre and the facilities there are used to provide special care on one day each week for children living within a reasonable catchment area of the hostel. Some small demand for this form of relief service became apparent in the Penrith area, and since the journey to an existing centre is considered too far for the grossly handicapped children involved, the possibility of establishing a similar unit on a part-time basis is being investigated.

Fifteen children were attending the Hensingham unit at the beginning of the year—4 on a full-time basis, 9 for three days each week, and 2 for two days a week—the aim being to keep the unit fully occupied and to ensure that every child thought suitable for this form of help received it in some measure. The periodicity of attendance in each case is governed by need and the geographical location of the Home. During the year one child was withdrawn from the unit because it was felt that the benefit accruing did not compensate for the upset of the lengthy journey to the unit. Two children were admitted (each for one day per week) so that at the end of the year 16 were receiving care.

At Orton Park there were six children attending for special care at the beginning of the year—one of whom was later transferred to full-time training at the Wigton Junior Training Centre. Two further children from the county area were admitted in 1969, and I was pleased to be able to comply with a request from the Medical Officer of Health for Carlisle to admit three children from the City to the unit. This increase in numbers to ten necessitated a minor adjustment to the level of staffing which now stands at one nurse (in charge) assisted by two attendants.

Locally there has been sufficient experience of the functioning of these units to raise doubts about their purpose and location. For the majority of the children attending these units at present, there is virtually no prospect of their being able to take part in the normal curriculum of the junior training centre. During the past year, out of a total of 26, only 1 child has progressed in this way although it is thought a further 2 may ultimately be able to cope with more formal training. Whilst the social benefits which accrue to families which contain a very seriously handicapped child are enormous, the predominant need for nursing care as distinct from training, leads one to think that this form of service might more appropriately be provided in day hospitals. One of the original purposes of special care units in association with local authority training centres was to cater for those children with a reasonable potential for training in the junior centres, but whose behaviour difficulties made direct entry into the classroom impracticable. This concept of "special care", as providing a period of socialisation and stabilisation of behavour pattern as a precursor to a more formal approach to training is largely being lost because of the overloading of the units with very seriously disabled children. The survival rate of these gravely handicapped children in early infancy is increasing and provision for their later care will undoubtedly present a mounting problem in the near future.

I am most grateful to Dr. Ferguson, Physician Superintendent, for providing day care facilities at Dovenby Hall Hospital for young adult subnormals who cannot benefit from training at an adult training centre, but the use of this valuable service is restricted at present to a relatively small catchment area within a reasonable travelling distance of the hospital.

(b) **For Adults**

Cumberland's first purpose-built training centre for adult subnormals was opened in 1965 at Distington and was designed to provide a two-phase development. In the first phase the training areas were adequate for fifty trainees of both sexes, but the dining, recreational and kitchen facilities were geared to the requirements of eighty trainees, the policy being to enlarge the capacity of the unit by adding additional training areas as a second phase of development when the need became apparent.

Although this extension was included in the Council's Development Programme for 1966/67, loan sanction was not forthcoming until 1968/69 and the building was completed in October, 1969. This delay in implementing a carefully considered policy was disappointing and resulted in a degree of overcrowding, but the postponement presented the opportunity of revising the original plans in the light of further experience. It became possible to bring the entire unit up to standards which were not available when the first phase was designed, and improvements were affected internally by more adequate provision for social education and externally in relation to outside work areas, the storage of materials and the bulkier finished products; and by some readjustment of access for vehicles.

The population to be served which is beyond the catchment area of the Distington Adult Training Centre (in the northern and eastern part of the administrative county) is approximately seventy thousand. Applying the "norm" figure of 0.59 per thousand for 1971 it was thought reasonable to plan the development of a centre for fifty trainees in this area during 1969/70. Since the area is about nine hundred square miles, the problem presented is one of location and it is logical, since there is no large conurbation in this part of the county area, to think in terms of the City of Carlisle for this development as being the natural focal point for transport. By arrangement with the Carlisle City Council those adult subnormals living within a reasonable travelling distance of the City receive training at that authority's new centre at Kingstown. This provision goes a fair way to meeting the need, but until boarding facilities are available some adult subnormals who are suitable for further training will not be able to attend for reasons of distance and transport difficulties. Mr. J. H. West, an Adviser on Services for the Subnormal, from the Department of Health and Social Security, spent a few days in June assessing these services in their geographical and social context. It was reassuring to have his recommendation that some joint provision of training facilities with Carlisle County Borough would seem to be logical.

In total, therefore, the authority's provision at Distington, together with that made available in the Carlisle centre represents 0.40 places per thousand population. This is below the national aim of 0.59 places per thousand by 1971, and I see little prospect of

any betterment until boarding facilities are provided to serve the sparsely populated areas in the north and east of the county. I am pleased to report that the County and City authorities are continuing their discussions so that opportunities for mutually beneficial joint planning are not lost.

The policy of training for the adult subnormal continues to be aimed at an appropriate balance for each individual between practical training along semi-industrial lines in the workshops with continuing social and further education. Attendances at adult training centres reached a record figure of 13,161 during 1969, which represents an increase of nearly 9% over the previous year. During 1969 there were two readmissions to training at Distington and 8 new entrants of whom 4 were transferred from juniors centres. The West Cumberland area is one which unfortunately has a high level of unemployment and it is pleasing to record that 4 trainees were placed in open employment. The extension at Distington involves readjustment of the training areas to different processes, with better facilities for outside activities and was not fully operational in its enlarged form by the end of the year. Inevitably there has been some dislocation of the training programme because of building operations, but this was minimised by careful phasing of the structural work with the cooperation of the County Architect's Department and the contractor. There was some decline in the total production of specific goods such as fencing panels, but a notable increase in sub-contract and assembly work. The range and extent of semi-industrial occupations during 1969 is summarised in the following list:—

Fabricated from basic materals

1. 1,072 interwoven fencing panels of various sizes.
2. 1,509 concrete paving slabs.
3. 13,200 builders wall ties.
4. 111 gross of wire coat hangers.
5. 64,350 wire frames for use by a packaging concern.

Sub-contract and Assembly Work

1. 303,200 forms printed for departments of the County Council.
2. 1,385,490 accumulator plugs assembled.
3. 154,220 plastic salt and pepper pots assembled.

4. Hospital supplies (safety pins, gauze, spigots, gallipots, etc.) packaged ready for autoclaving as required by local hospitals.

Every trainee receives 2/- for each day's attendance, out of which they have the practical experience of paying (in cash) 1/- for their lunch. In 1968 an additional payment for attitude to work, effort, diligence and general conduct was introduced, the extent of this supplement being at the supervisor's discretion to a maximum of a 1/- per day. It was felt that some of the trainees merited a greater monetary reward for their efforts and the committee agreed that the upper limit of supplementary payment be raised to 3/- a day so that the total can now reach 5/- a day.

It is becoming increasingly evident that the further training of the young subnormal in adult training centres towards a higher level of independence and social competence should not be undertaken in isolation and completely divorced from separate enterprises for other types of handicap. Inevitably there will remain a high proportion of handicapped people who, because of their physical and/or mental disability, are unable to compete in the open labour market. I suggest that they all have an equal basic right to the opportunity to make their contribution to society through the medium of sheltered employment and that they, in their turn, must be accorded the dignity of an adequate reward for their efforts. In this increasingly competitive technological age which demands higher levels of training for all types of employment, the tendency is for those with mental or physical infirmity to find themselves in an increasingly unfavourable position. It seems illogical, therefore, that attempts to resolve these difficulties should be undertaken by different agencies and for different disabilities—all too frequently in some degree of competition with each other. Government Training Centres, Industrial Rehabiltation Units, Remploy, Workshops for the Blind, Training Centres for the Subnormal, hospital based rehabilitation units along industrial lines, are all playing their part in the total scene. Surely the time is ripe for an attempt to be made to co-ordinate all this effort and to formulate a multi-disciplinary organisation which would not only be more efficient but offer more satisfactory employment prospects for all those who, because of a handicap of any type, find it difficult to secure employment.

Hostel Accommodation

(a) For the Mentally Subnormal (Junior)

The hostel at Orton Park for subnormal children continues to provide boarding facilities during the week for the duration of training centre terms for those children who, because of the remoteness of their homes, would otherwise be unable to attend a centre for junior subnormals. Although the hostel was opened in 1959 it was only on very rare occasions that the total accommodation (22 places) was fully occupied. A number of older children were transferred to an adult training centre and no longer needed the residential provision, but their places at the hostel were quickly taken up by very young children. The demand for boarding at Orton Park to enable training to be given has risen at a steady rate durng the past five years, as is shown by the annual resident day figures:—

1965	...	2,562
1966	...	2,822
1967	...	3,025
1968	...	3,296
1969	...	3,412

The present position is that the hostel is now full, but the significant factors are that the proportion of young children is much greater—10 under eight years by comparison with 4 as recently as eighteen months ago—and that since the oldest child is now only thirteen years of age it is unlikely that vacancies will arise during the next two or three years, and certainly none as a result of transfer to training in a centre for adults. Towards the end of the year it was found necessary to appoint a night attendant because of the high proportion of quite young children, and because there were 3 residents with epilepsy and 1 who was hyperkinetic. This was the first time in rather more than ten years when there was night staff employed as distinct from resident staff being "on call". The alternative would have been to impose much stricter limits on the type of child admitted.

The children are, of course, only resident for four nights a week and return home each weekend and for the training centre holidays. I am happy to report that senior pupils from local schools continue to help in entertaining and playing with the children in the early evenings. The Wigton Round Table has

undertaken to provide an adventure play-ground which is partially completed at the time of writing. This involvement of the community and especially by the young people with the work of the hostel is most welcome and encouraging.

Orton Park, being adapted for the residential care of children and vacant during school holidays, presents an admirable location for children's holidays, and has been used for this purpose by visiting parties of subnormal children from other areas. During this summer the Committee gladly agreed to allow the Women's Royal Voluntary Service to use the premises for a week, so that they could arrange a group holiday for 20 boys and girls from Cumberland, the participants being nominated from needy families by my staff.

(b) **For the Mentally Subnormal (Adults)**

In this area it has been thought that the primary ascertained need for providing hostel accommodation for subnormal adults was to allow those living in the more remote areas to participate in training at an adult centre. To meet this situation, particularly in East Cumberland, an earlier capital development programme included a small hostel of 10 places in the period 1971/76. Whilst this need remains it has now been decided to increase and accelerate the provision of hostels for adults by building two 20 bedded units—the first in 1970/71, and the second in 1972/73. If these projects maintain their position in the programme the rate of provision at 0.18 per 1,000 population will be slightly higher than the national aim for 1976. This amendment of policy has been stimulated by the recognition of a growing need to assist in the return to the communty of those subnormals at present in hospital who no longer need medical or nursing care, and to make suitable accommodation available within the community for those adults who may need it for purely social reasons.

completed at the time of writing. 8his involvement of the com-

If the concept of care in the community is to be implemented I feel sure that the local authorities will need to provide accommodation either in hostels or in private lodgings for subnormals at an accelerating rate (a) so that subnormal patients can be discharged from hospital care when the need for hospitalisation is over and (b) where the need arises from social factors (such as the death of a caring relative) to enable the subnormal to remain

within the community without recourse to the hospital provision which for so many years has been the only source of "care" in social emergencies.

(c) **For the Mentally Ill**

When the hostel for the mentally ill (Fairview) was built at Whitehaven in 1966 it aimed to provide a "halfway house" in a secure environment so that the residents could be helped to adjust to life in the community after treatment in hospital. It also offered temporary accommodation at times of social crisis for those in the community who were suffering from a mental disorder which did not require treatment in hospital. Nationally this was a relatively new and untried provison and, since the extent of the demand was uncertain, the hostel was built initially to cater for 17 residents but designed so that its capacity could easily be extended to 30.

The following tables give statistical data to date:—

Admissions:	**1966**	**1967**	**1968**	**1969**
From Garlands Hospital	15	5	16	18
From West Cumberland Hospital	2	4	4	7
From Dovenby Hall Hospital	—	—	2	1
From Other institutions	—	—	1	6
From home	12	8	7	15
Readmissions from seasonal employment	—	2	6	4
TOTALS	29	19	36	51

Discharges:	**1966**	**1967**	**1968**	**1969**
To home, relatives or lodgings ...	5	12	15	23
To residential employment	4	5	10	9
To hospitals	6	5	6	13
Absconded	—	2	—	2
Died	—	—	—	1
TOTALS ...	15	24	31	48
Average occupancy	42.7%	59.6%	71.2%	86.0%

Diagnosis	In residence at 1.1.69	Admitted	Discharged	In residence at 31.12.69
Schizophrenia ...	8	21	19	10
Subnormality ...	3	11	9	5
Depression ...	1	7	7	1
Alcoholism ...	1	5	5	1
Epilepsy ...	1	1	2	—
Inadequate personality	—	4	4	—
Psychopath ...	—	2	2	—
TOTALS ...	14	51	48	17

In terms of numbers rehabilitated to a normal life in the community it can be claimed that the hostel has been successful in that since it opened 83 people have been able to return to their homes, relatives, into lodgings or to residential employment. This figure represents almost 70% of those admitted. Equally encouraging has been the undoubted success, as a result of determined and highly commendable effort by the hostel staff and the social workers, in finding work for so many who as a result of very long periods in hospital (in some cases upwards of ten years) had virtually been "written off" as unemployable.

Towards the end of 1968 I reported at some length to my Committee on the persistent under-occupation of the hostel. I am glad to report that this difficulty with its obvious impact on patient-week costs has largely been resolved and the average occupancy has climbed steadily from 42% to 86%. During this time the average age of the resident has increased, as has the number of subnormal cases who must inevitably be regarded as longer term residents. Nevertheless it was not until Fairview had been opened for three years almost to the day that all 17 beds were occupied.

Endeavours to stimulate the use of the hostel have included an arrangement whereby the warden attends the weekly case-conference which is held between the consultant psychiatrists at the West Cumberland Hospital and my social workers in the Southern and Western areas of the county, the regular visiting of the hostel by the senior social worker from the Garlands Hospital and an acceptance of selected long stay hospital patients into

Fairview to give them a short holiday outside the hospital. The price paid in achieving a degree of occupation which, in these days of financial stringency, would justify the hostel's continuance has been a considerable dilution of the criteria for admission—including the acceptance of residents whose major disability is mental subnormality. This, unfortunately, has been the pattern of development experienced by many of those authorities who have ventured into this field.

An analysis of those in residence at the end of the year reveals that the ages of the residents ranged from 28 to 81 years—the average being 55 years. One female resident had been at Fairview since March, 1967, and the average stay was just over nine months. Those discharged from the hostel during 1969 numbered 48, the average period of residence being 33 days.

Mr. Walker, Senior Social Worker at the Garlands Hospital reports:—

> "Several long stay institutionalised patients from the Garlands Hospital were selected for a fortnight's holiday at Fairview. In so doing, it was hoped that a longer period of assessment for discharge to welfare Homes or other accommodation might possibly be justified in a few cases. The results to date have been most encouraging because even very long stay patients (in one case 58 years hospitalisation) have ultimately been considered suitable for discharge from hospital to the community. Even those who returned to the hospital on completion of their holiday have benefited greatly from this experience."

On the one hand, therefore, we have the situation that this hostel is undoubtedly providing a very useful service for the mentally disordered, but against this the experience of the past four years indicates quite clearly that the demand for rehabilitative facilities for those recovering from a mental illness has been overestimated and could be met by a much smaller unit. The rate at which those suffering from mental subnormality have been admitted has been kept under close control because residents of this type create problems in a small community out of proportion to their numbers and are much more difficult to integrate into the rehabilitative activities of the hostel. The expected opening of a separate unit in Workington in 1971 for adult subnormals will provide a more suitable environment for those subnormals who,

in the absence of any other provision are at present accommodated at Fairview. The tendency to an increasing accumulation of a chronic population who seem unlikely to achieve rehabilitation to a degree which will allow them to maintan a reasonable life in the community is a constant source of anxiety. In these days when residential accommodation for so many varying types of handicapped and inadequacy is at a premium, it may be considered that the hostel at Whitehaven could be put to better use for some other purpose if a less expensive provision such as family size units were made available for the resettlement of the mentally ill in the community.

Social Clubs, Etc.

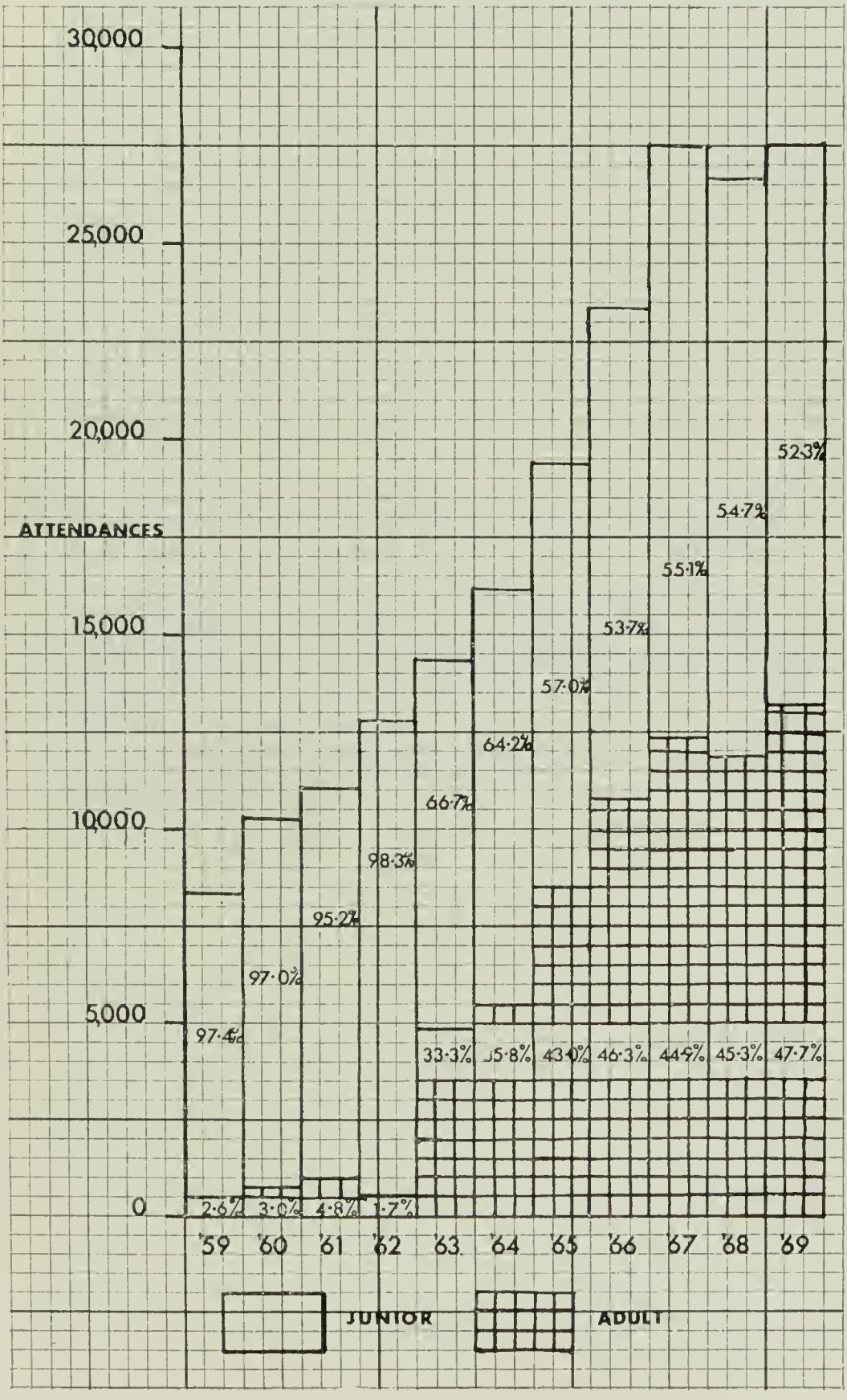
The evening club activities which were started in Whitehaven for psychiatric clients several years ago and which later developed into two separate clubs because increasing membership justified a reduction in the catchment areas (and hence in travelling) continued to flourish. Both hold weekly meetings in centres provided by the authority at Flatt Walks, Whitehaven, and at Princess Street, Workington. The members appoint their own officers to run the clubs but my social welfare officers give active but discreet support. The Whitehaven club opens its facilities to those currently resident at the post-psychotic hostel at Fairview and occasionally arranges its weekly meeting at the hostel. The sparsity of population outside the West Cumberland area makes it difficult to find a viable membership within reasonable evening travelling distance of any single location, but this situation is kept constantly under review and my staff in the Northern Area seem to think that it may be possible to start a social club in the Penrith Area in the not too distant future.

So far as the adolescent subnormal is concerned the policy has always been towards integration with the normal youth clubs and groups and this is done as far as practicable. At the same time it has been felt that the initiative should be taken for those who, because of the absence of suitable youth associations in their particular area, have been unable to participate in group social activities. With the generous support of the Parents' Association and young people from the local grammar school such a club was started in the Council's Social Centre at Whitehaven in 1968 and

continues to function very happily with an average attendance of about 24 at the fortnightly evening meetings. A local firm provides transport to and from the club.

A play group is organised by the Parent/Teacher Association for children from the Hensingham Junior Training Centre which meets on two afternoons each week during the training centre holidays. This is also held at the Whitehaven Social Centre and is manned by the parents on a rota system. Necessary transport is provided by the Parent/Teacher Association.

TRAINING CENTRE ATTENDANCES



AMBULANCE AND SITTING CASE CAR SERVICE

Section 27 of the National Health Service Act, 1946

"It shall be the duty of every local health authority to make provision for securing that ambulances and other means of transport are available, where necessary, for the conveyance of persons suffering from illness ..... or expectant or nursing mothers from places in their area to places in or outside their area."

COUNTY AMBULANCE SERVICE

Demand for the Service

This year has seen a reversal of what has been, over recent years, a continual increase in the use of the Service. The mileage has shown a slight increase of 9,401 to 1,229,821 (just under 1%) but the number of patients has dropped by 1,144 to 121,679 (roughly 1%). The possibility of a lessening in demand was commented on in my Report last year. The decrease is mainly due to a reduction in the transport provided to convey mentally sub-normal patients to Training Centres, while two factors chiefly account for the mileage increase. Firstly the catchment area for geriatric cases conveyed to consultants' clinic at West Cumberland Hospital has been enlarged and there is a continuing increase in out-of-county mileage to the Newcastle hospitals. Another factor which helped to sustain the mileage level has been the need to arrange later separate transport home for patients delayed at hospital still awaiting treatment, rather than delay the return home of other patients whose treatment was completed. This matter has been repeatedly drawn to the attention of the hospital staffs concerned but little impact has been made and it is doubtful if much can be expected with the present size of some of the clinics. The number of road accidents attended remained almost exactly the same; eight occurred on the Penrith By-Pass involving twenty-one patients, but fortunately none were seriously injured.

Mr. Butler, Superintendent, Bush Brow Control Station writes:

"Overall the number of patients remained fairly constant but there was a significant decrease in the mileage in this area of 15,000, which has been achieved in spite of the need to provide special transport for patients who are delayed at clinics. It, therefore, reflects great credit on the staff, both in the ambulance service and at the Cumberland Infirmary, in their continuing efforts to effect closer co-ordination of work and the maximum use of man-power. Unfortunately, I cannot envisage this reduced level of mileage being maintained due to the increasing number of journeys to the Kidney unit at Newcastle.

During the course of the year every effort has been made to ensure the fullest possible use of all vehicles which has resulted in a reduction of the work undertaken by the Hospital Car Service".

The out-of-county mileage has now reached 219,000 an increase of 13,000 miles over last year. 34,500 miles is accounted for by patients travelling to the Artificial Limb and Appliance Centre, Newcastle. However, as a result of the concern expressed by the County Council over the difficulties involved in conveying patients to and from this Centre, agreement has now been reached between the Department of Health and Social Security and the Special Area Committee for premises at the Cumberland Infirmary to be adapted to provide a temporary Centre pending the provision of a permanent Centre as part of the long term hospital plans. It is anticipated that the temporary facility will come into use towards the end of 1970 but, in order to do something to alleviate the position immediately a room has been made available in the Northern Area Health Office for use by the Medical Officer from the Newcastle Centre to see certain patients here in Carlisle rather than Newcastle. It has also been agreed with the Newcastle Regional Hospital Board for beds to be provided for use by patients attending the Newcastle Centre whose physical condition warrants an overnight stay in Newcastle rather than having to make an exhausting journey on the same day.

325 home accidents to which ambulances were called out were reported to the Area Medical Officer for investigation. This is a slight increase over the previous year, the majority being accounted for by falls in the home, viz 44% as compared with 47% last year. The percentage of poisoning cases from overdoses was 26% compared with 25%, while scalds and burns dropped from 9% to just over 7%.

During the year eight births in ambulances were satisfactorily dealt with, which once again emphasises the value of, and need for, emergency midwifery training for all ambulance personnel.

During the year it was necessary to arrange one helicopter journey from West Cumberland Hospital to the Lodge Moor Hospital, Sheffield. Unfortunately no suitable helicopter was available at R.A.F. Acklington and an aircraft was sent from a station in Hampshire.

The Management Services Unit of the County Council commenced work on their comprehensive review of the Ambulance Service in September. It is unfortunate that the start was delayed because of inter-union difficulties.

Staff

A very pleasing ceremony took place on 6th October, when the Lord Lieutenant of the County presented Mr. J. Grieve, an ambulanceman at Bush Brow Station, with the British Empire Medal which he was awarded in the Birthday Honours List.

There is no doubt that this award was very well deserved and, besides being a personal tribute to Mr. Grieve, reflects great credit upon the Cumberland Ambulance Service.

National Safe Driving

All personnel were entered for the National Safe Driving Competition and, for the first time ever, every driver qualified for an award. This 100% record reflects great credit upon all concerned.

There is no doubt that sufficient exercise is of great importance to a person who continually drives. With this in mind, the staff are being encouraged to establish in-door sporting activities at their station. This has already been done at one station and others, while accepting the principle, have not yet decided what form the activities should take.

Training

Drivers in both East and West Cumberland continued the one week's in-hospital training programme at both the Cumberland Infirmary, Carlisle, and the West Cumberland Hospital. This has now become accepted by the hospital staff as a permanent feature of the training of ambulancemen and I am greatly indebted to the hospital consultants and other staff undertaking the training, and to the Hospital Management Committees for putting these facilities at our disposal.

There is no doubt that as a result of in-hospital training, ambulancemen are able to appreciate the day-to-day problems which arise in hospitals and this has led to close and harmonious working between ambulancemen and hospital staff, both appreciating the need for team work.

Sister Walker, Accident and Emergency Department, Cumberland Infirmary, writes:—

> "Thank you again for the opportunity of commenting on the County Ambulance Service. Once again the further periods of training in the Accident Department of the Cumberland Infirmary have served to improve the team work which is so essential in the management of injured patients. The

men have in some instances been able to see the results of putting their training in resuscitation methods to practical advantage—in particular airways, splints and dressings.

There has been some reluctance to fill in the pro formas provided in the Accident Department, in which they have been asked to fill in such details as an estimate of blood loss, level of consciousness and nature of the injuries; there have been several occasions when it has been of very considerable value in enabling the surgeon to take more effective immediate or later action, and it is to be hoped that they will continue to fill in these forms.

We feel that the next step in the care of accident victims, which should be a continuous process on the part of one large team, would be to hold regular joint meetings of representatives from all the rescue services concerned throughout the County".

Sister Anderson, Out-patient Department, West Cumberland Hospital comments:—

"The ambulance service plays an important part in the efficient running of any out patient department. We rely on the service to bring patients into the department in good time for their appointment. I also feel that there should be a good liaison between the two services. The attitude of the drivers towards patients is also very important. In this area I find the relationship very good indeed.

Here I feel I must pay special tribute to the way in which the senior citizens are cared for by the ambulancemen and also to the crews from outlying districts who tend their "Flock" like the proverbial shepherd".

In June ambulancemen were awarded increases in pay dependent upon having achieved a satisfactory level of training and competence based on the Millar Report on Training. The amount of the increase was determined by length of service and the nature of their work. In assessing the competency of the 42 ambulancemen eligible, account was taken of the fact that they held a Certificate in Advanced First Aid and in addition have received continuous in-hospital training since their entry into the Service. They were, therefore, all considered eligible for the increases.

The remaining drivers are all recent entrants to the Service and arrangements are being made to send them to an existing Regional Training School next year for a six week training course as recommended in the Millar Report. Plans are being made to set up such a school in Newcastle which, once established, will be able to meet our future basic training needs.

Twenty-one drivers have been presented with a Proficiency Certificate in Ambulance Aid. These are issued by the Ambulance Service Advisory Council to those drivers who have achieved the required standard of training and who are engaged on the full range of ambulance duties. A further twenty-one will become eligible next year. The remainder, who are recent entrants, will become eligible after they have successfully completed a six weeks' training course.

Holders of these Proficiency Certificates will no longer need to requalify annually in first aid but will be required to attend refresher courses as arranged by the employing authority.

Events have, therefore, justified the wisdom of the Committee's policy of continuous in-service (including in-hospital) training by way of making grants available for private study and also by arranging refresher courses at hospital.

Mr. Mossop, Superintendent, Distington Ambulance Station writes:—

> "Looking over the past year, it has become more and more evident, that the Ambulance Crews are fast becoming the "specialized technicians" that has always been our aim.
>
> One can only be convinced, that this is the result of a well organized training schedule, both at station level, and of regular weekly periods spent at the hospitals within the group. There is an almost one hundred per cent proficiency record, for which we can be justly proud.
>
> The emphasis must be surely two fold. Firstly, the adoption of the new term "Ambulance Aid" replacing the former term of First Aid, and secondly a great deal more can now be done at the scene of any emergency, to reduce the level of physical pain, and mental discomfort of the patient".

Mr. Butler, Superintendent, Bush Brow Control Station comments as follows:—

> "During the year all personnel have again had one week's training at the Cumberland Infirmary. This has been greatly

appreciated by all. It has now become an annual part of their training.

There are several things which have given me great satisfaction during the year. Firstly, there is the manner and enthusiasm with which the staff have approached their work. Secondly, that all personnel have gained a "No Accident" Award for safe driving. Thirdly, that a team from Bush Brow Ambulance Station which competed in our own inter-station first-aid competition held at Workington, won the three major prizes. The same team also competed in the regional competition held in Newcastle. Although they did not do quite so well, they did bring back the cup for the best driver-attendant".

During the year talks on the operational work of the service generally, and in particular the procedure in dealing with road accident casualties, have been given by officers of the service to all County Fire Service personnel. The basic aim was to improve co-operation at the scene of an accident when both services were in attendance to the ultimate benefit of the accident casualties. They were a great success and stimulated an interchange of ideas and information. They were thoroughly enjoyed by all who took part.

Stations

The purchase of the site for an ambulance station at the Cumberland Infirmary, Carlisle, has still not been completed, the delay being due to protracted negotiations which the Regional Hospital Board are having with British Railways in the acquisition of the land. This should not delay the commencement of the building as permission for access to the site has been given. Because of site difficulties the cost limit has increased from £50,125 to £54,481 and this has been approved by the Department of Health and Social Security.

The premises at Bush Brow have been in use since the direct service was introduced in June, 1962, and were then considered to be only temporary. The facilities they provide are quite in adequate and it says a great deal for the devotion of the staff that they have accepted the position without complaint for so long.

Vehicles

During the year orders were placed for two traditional Bedford Ambulances and three Bedford/Lomas Dual Purpose Vehicles.

Unfortunately, on placing the order information was received that the chassis used in the past for dual purpose vehicles was being phased out of production and was no longer available. As these replacements were urgently required, and to avoid further delay, it was decided to order the Ford Custom chassis for these vehicles, although it was more expensive. Delivery is expected towards the end of the financial year. Unfortunately, owing to the industrial difficulties affecting the supply of chassis for the traditional ambulances, it is unlikely that the new vehicles will be delivered until after the beginning of the next financial year. The delay in the provision of these replacement vehicles is bound to be reflected in increased fleet maintenance costs. While a standardised fleet of vehicles has its advantages, there is no doubt that industrial action affecting deliveries leaves the fleet operator in an exposed position, but the effect would be lessened by operating a mixed fleet. When further replacement vehicles are ordered serious consideration will need to be given to this matter.

Hospital Car Service

Once again the members of the Hospital Car Service have done an enormous amount of work on behalf of the Ambulance Service, covering 579,348 miles. There is a reduction of 46,973, compared with last year's total but it must be remembered that the number of active drivers has been reduced, owing to a number of reasons the majority of which are personal, to 80. I am most grateful to all those who continue to give such devoted service.

The following comments of two Hospital Car Service drivers are also very interesting.

Mrs. Bold from Workington writes:—

> "I have always found that the patients I carry are always most co-operative. I think if all drivers are courteous with their patients, do all in their power to help them, and are pleasant and kind none of us will ever have any problems.
>
> One must of course drive very carefully, and not take any risks, because this apparently is one of the main things which is likely to upset patients very much. I feel that at least patients must trust me".

Major Drinkwater from Raughton Head comments:—

> "I have come in contact with some very wonderful people who are bearing their problems cheerfully and they have great faith in the treatment being provided for them.

I found that the best way of going about the work was to gain the confidence of the people to be carried, to allow yourself ample time to do the picking up and get the patient to the hospital in time for the appointment. Most of the people are worried in case they should be late for the Appointment. I have always tried to get my people to the appointment place about 10 minutes before the time stated on their card. I have only failed once and that was in December last when I got stuck in a snow drift on the Caldbeck Fells. It is always important to be available on the spot to collect them after they have had their treatment.

I am lucky that my employment with the Ministry of Agriculture took me into all the villages in my own area so that I can plan my route before I start out.

I have gained great satisfaction from doing the service and I am very thankful to you and your staff for giving me the opportunity to serve others".

I am grateful to Dr. Loudon who writes on behalf of himself and his partners for the final comment:—

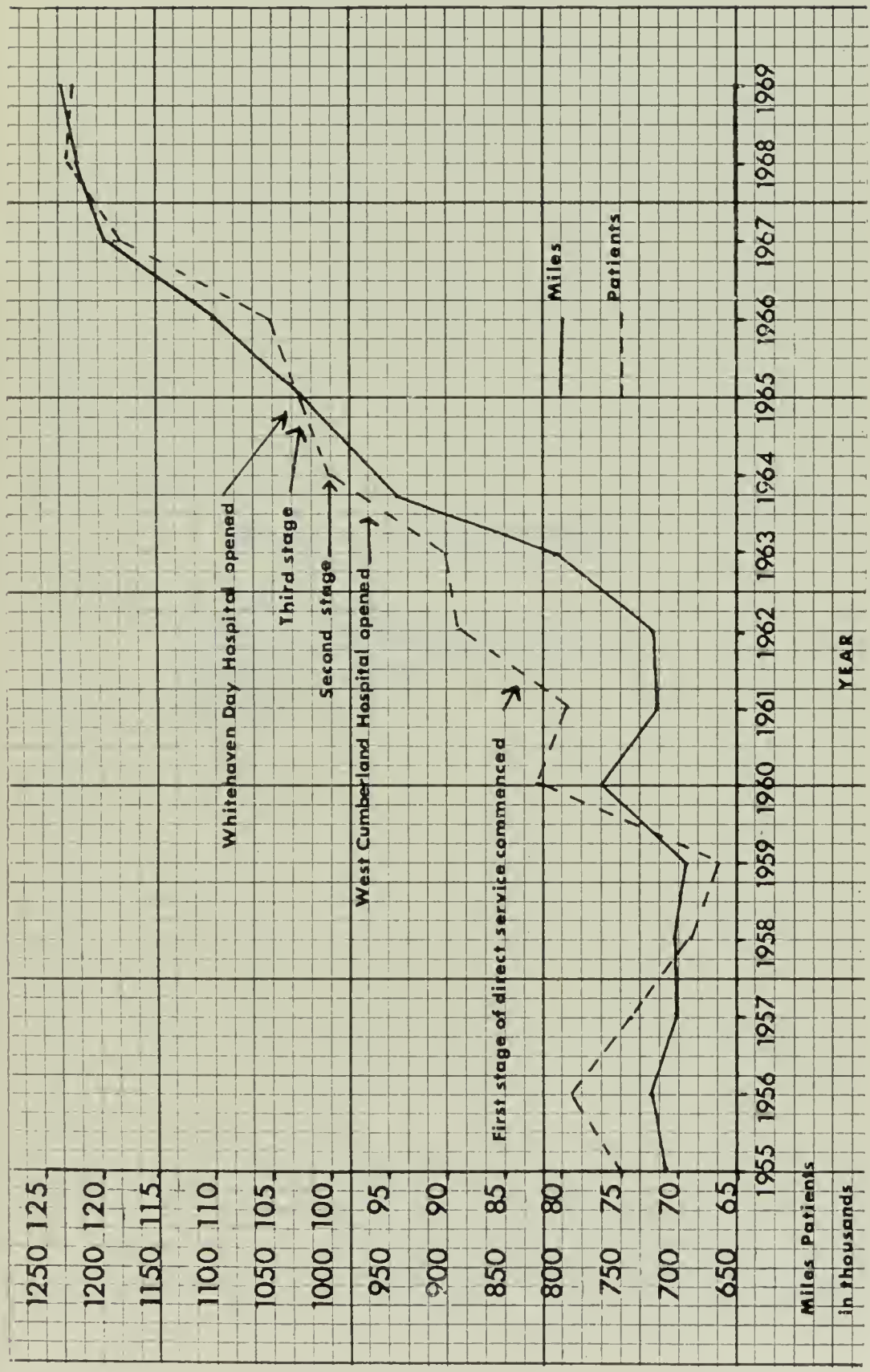
"We all consider that the Service is excellent in its personnel and organisation, always ready to help within its terms of service, and sometimes without such terms. Having our own radio communication on the ambulance frequency makes us aware of the almost continuous demands being made on the Service, and the difficulties met by those organising and running it.

Our only adverse comment is one which I am sure you would wish to endorse, and that is that the vehicles themselves are, like many such vehicles in this country, ill-designed and equipped for a modern ambulance service, and a little increase in the County rate to cover the provision of some new vehicles would be hard to criticise".

I am sure no-one will disagree with Dr. Loudon's comments on the short comings of the modern ambulance but some comfort and hope for the future can be gained with the knowledge that the question of ambulance design is being actively considered on a national level by the Ambulance Service Advisory Council.

		Ambulances		Sitting-Case Cars		Hospital Car Service		Summary of all Services	
		Total number of patients carried	Total Mileage	Total number of patients carried	Total Mileage	Total number of patients carried	Total Mileage	Total number of patients carried	Total Mileage
1968	Agency Service ...	912	13789	4073	29712	1303	35130	6288	78631
	Direct Service ...	73429	550598	—	—	43106	591191	116535	1141789
	TOTAL ...	74341	564387	4073	29712	44409	626321	122823	1220420
1969	Agency Service ...	495	14727	3357	25506	1091	30090	4943	70323
	Direct Service ...	80047	610240	—	—	36689	549258	116736	1159498
	TOTAL ...	80542	624967	3357	25506	37780	579348	121679	1229821
Increase or decrease compared with 1968		+6201	+60580	—716	—4206	—6629	—46973	—1144	+9401

CUMBERLAND — GROWTH IN THE USE OF THE AMBULANCE SERVICE



GENERAL PUBLIC HEALTH

Infectious Diseases
Inspection and Supervision of Food
Water and Sewerage
Housing

INFECTIOUS DISEASES

The table of notifications of infectious diseases for 1969 is shown on page 215 The figure for measles is lower than ever before but nevertheless disappointing. A set back in measles vaccination during 1969 due to the withdrawal of supplies, contributes to the figure being even as high as it is, but the notification level even at the time of writing this report is disturbingly high for certain areas of the county. I have asked Area Medical Officers to give the highest priority to comprehensive measles vaccination now that supplies of vaccine are again becoming available.

Notifications of infectious jaundice have increased in 1969 but this is only the second year that this condition has been notifiable and it will take a little time for it to become apparent at what level local and national figures tend to settle. With the epidemiology of this infection still very imperfectly worked out, efforts at prevention of spread must centre on good personal hand hygiene.

NOTIFICATION OF CASES OF INFECTIOUS AND OTHER NOTIFIABLE DISEASES 1969

	Scarlet Fever	Whooping Cough	Poliomyelitis	Measles	Dysentery	Acute Encephalitis Infective	Post Infectious	Enteric or Typhoid Fever	Paratyphoid Fever	Food Poisoning	Tuberculosis Respiratory	Meninges and C.N.S.	Other T.B.	Puerperal Pyrexia	Ophthalmia Neonatorum	Infective Jaundice	Scarletina	Leptospirosis
URBAN DISTRICTS—																		
Workington ...	17	—	—	106	1	—	—	—	—	—	10	—	2	—	—	5	—	—
Whitehaven ...	10	—	—	18	1	—	—	1	—	—	6	—	6	—	—	16	1	—
Cockermouth ...	—	—	—	9	—	—	—	—	—	—	3	—	—	—	—	—	—	—
Keswick ...	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—
Maryport ...	29	—	—	—	—	—	—	—	—	—	1	—	1	—	—	—	—	—
Penrith ...	1	1	—	23	12	—	—	—	—	—	—	—	1	—	—	29	—	—
RURAL DISTRICTS—																		
Alston ...	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Border ...	1	—	—	102	5	—	—	—	—	17	8	—	—	—	—	14	—	—
Cockermouth ...	11	—	—	15	1	—	1	—	—	—	5	—	—	—	—	2	—	—
Ennerdale ...	5	—	—	47	—	—	—	—	—	—	3	—	1	—	—	1	—	—
Millom ...	1	—	—	8	1	—	—	—	—	—	—	—	1	—	—	1	—	1
Penrith ...	3	—	—	11	18	—	—	—	—	—	2	—	—	—	—	12	—	—
Wigton ...	6	—	—	61	—	—	1	—	—	—	2	—	—	—	—	2	—	—
TOTAL FOR YEAR	84	1	—	401	39	—	2	1	—	17	41	—	12	—	—	82	1	1
1968 ...	55	51	—	742	303	—	—	2	2	2	39	1	10	2	—	46	—	—
1967 ...	60	76	—	2204	37	—	—	—	—	2	46	—	11	11	—	—	—	—
1966 ...	184	83	—	1183	14	—	—	1	—	4	54	—	13	33	—	—	—	—
1965 ...	76	17	—	3480	261	—	—	—	31	10	56	2	10	7	—	—	—	—
1964 ...	119	152	—	1064	12	—	—	—	1	4	73	2	13	2	2	—	—	—
1963 ...	23	119	1	1836	50	—	—	1	—	31	76	1	12	12	—	—	—	—

Food and Drugs Act, 1955
Summary of work done under the above Act during the year ended 31st December, 1969

Total Samples Obtained		Genuine		Unsatisfactory	
Milk	Other Foods	Milk	Other Foods	Milk	Other Foods
559	257	452	250	107	7
816		702		114	

During the year 816 samples were obtained, 559 being milk and 257 were various foods and drugs. Of these 36 milk and 229 others were analysed by the Public Analyst and the remainder were tested by the Sampling Officers.

In addition to the ordinary compositional analysis, samples of farm bottled milk have been tested by the Analyst for the presence of antibiotics but none were detected.

The average quality of the milk tested by the Sampling Officers including 96 below standard, was 3.72% fat and 8.63% solids-not-fat compared to the presumptive standard of 3.0% and 8.5% respectively.

The percentage of unsatisfactory samples, of the total number obtained, was 14 compared to 6.2 the previous year. This increase of some 8% was mainly due to the greater number of unsatisfactory milk samples which were found when concentrated checks were made on consignments of milk suspected by wholesale dairies of being poor in quality.

Unsatisfactory samples were dealt with as follows:—

Milk:

Of the 107 unsatisfactory milk samples 11 were submitted to the Public Analyst. One, which was taken as a result of a complaint from a wholesale dairy, contained 6.5% of extraneous water; the producer was prosecuted and fined £25 plus costs of £20/6/- awarded to the County Council.

The attention of a farmer was drawn to the fact that his milk contained 2.3% of extraneous water. The only explanation offered was that water might have been left in the pipelines after cleansing. Agricultural engineers modified the installation to eliminate the possibility of water being trapped.

One sample, purchased at a camping site shop, was deficient in fat to the extent of 50.0%. The milk had been supplied to the shop by a dairyman who bottled it after obtaining a bulk supply from a farmer. A further sample, taken at the farm from which the milk was supplied, was satisfactory. There appeared to have been negligence in the mixing of the milk before bottling therefore the dairyman was prosecuted and fined £2.

The attention of one producer was drawn to a sample which although of genuine quality, was below standard in non-fatty solids.

Three unsatisfactory samples, from a batch of ten taken from one producer, contained extraneous water, the quantity present being 3.7%, 5.0% and 9.1%. Proceedings were instituted each of two partners being fined £10 with total costs of £15.

Four other samples from one source contained extraneous water and from investigations made it appeared that the method of washing the pipes of the installation called for extreme care to avoid water getting into the milk. The producer was advised to change the method of cleasning and was also told that any similar offences would in all propability result in prosecution. Frequent checks were later made on milk from this source with satisfactory results.

The remaining unsatisfactory samples were among those tested by the Sampling Officers and not submitted to the Analyst. With the exception of some informal samples, deficiencies in non-fatty solids were slight and freezing point tests indicated that the deficiencies were not due to the presence of extraneous water. The informal samples which contained added water led to formal samples being submitted to the Public Analyst and to these reference has already been made. A few samples were deficient in fat but further samples from the same sources were found to be satisfactory.

Unsatisfactory items other than milk:

One of the problems with which shopkeepers dealing in food have to contend is the proper circulation of stock. Certain foodstuffs when kept in stock too long deteriorate in quality and this tends to be overlooked as in the three following instances.

Some sponge pudding mix was found to contain fat with a higher acidity than was desirable for edible purposes. The matter was taken up with the manufacturers and they established

from a code marking that the mix was packed in November, 1967 and its shelf life had been long exceeded therefore they arranged to check the retailer's stock of their products.

A bar of chocolate rum truffle contained a negligible amount of rum despite prominence given to the word 'rum' on the wrapper. The manufacturers claimed that the chocolate had been held in stock by the retailer for some time resulting in a loss of rum by evaporation. As there appeared to have been some laxity regarding stock circulation somewhere in the chain, the manufacturers were advised to try and introduce some control which would obviate cause for further complaint.

Some baking powder was found to be deficient in available carbon dioxide and, once more, enquiries indicated that the product was old stock. It could not be established at which point in the chain of distribution the baking powder had exceeded its shelf life of approximately twelve weeks therefore all parties concerned were given suitable advice.

A sample of "low calorie sugar" cubes consisted of 97.7% sugar and 2.3% of sodium cyclamate. It is not permissible to apply the description "sugar" to a compound article of this nature but, because it had just been declared that the use of cyclamates was to be banned in this country, no further action was taken apart from drawing the attention of the manufacturer to the matter.

The presence of preservative in sausage has to be declared either verbally or by notice and the attention of one butcher was drawn to this requirement in respect of a sample of mixed beef and pork sausage.

A soft drink sold with the description "Non Alcoholic Raisin Flavour" was found to contain 2° proof spirit. It was considered that the description was incorrect and the manufacturer agreed to have the labels amended.

Regulations came into operation which prescribe minimum meat contents for sausage rolls and pies and tests have been made on a number of these products. The tests indicated that the meat content was satisfactory with the exception of some pies which were doubtful but a formal sample submitted to the Analyst was found to be satisfactory.

Complaints of unsatisfactory food:

Several complaints concerning unsatisfactory food were received during the year all being in respect of 'foreign bodies' in

the food. One concerned a school canteen where a pupil was served with a portion of pie which contained a beetle type insect. It was impossible to establish where the beetle came from or how it had got into the pie and no further action was possible.

Another complaint, also from a canteen, concerned a cigarette end found in a tin of apples. Unfortunately legal action could not be taken against the packers in N. Ireland but, in view of the serious nature of the offence, consideration was given to proceedings being taken against the importers. However it was decided not to do so because, even if they had taken precautions by opening and inspecting random tins of apples, the chance of opening the tin containing the cigarette end would have been extremely remote. The importers were cautioned and they took up the matter with the packers and stressed the extreme gravity of this type of offence.

Examination of a sealed packet of shelled nuts which had been purchased revealed the presence of live white grubs. This complaint was passed on to the Public Health Inspector for the area who arranged to visit the retailer and condemn any remaining unsatisfactory stocks and also to draw the attention of the manufacturers to the matter. Apparently nuts are particularly prone to grubs of this kind and although a non-toxic spray is used as a preventative if an odd nut is missed the larvae can germinate and multiply.

A final complaint was in respect of a wire nail found in a pack of Greek sultanas. This was another case of being unable to take direct action against the packers. The importers were very concerned about the complaint and stated everything was done by them to impress upon the packers in Greece the need for the fruit to be of a high standard in cleanliness.

Housing, Water Supplies, Sewerage Schemes and Caravan Sites

This year I am including comments from the Clerks and District Medical Officers who have kindly given me information on environmental conditions and plans for their districts.

As in last years Annual Report I have combined these comments with the usual annual data on housing, rural water supplies and sewerage provided by the Clerk of the County Council.

Housing

Of the 403 houses declared to be unfit in Penrith Urban District in 1954 only 60 now remain. These 60 houses will be

re-surveyed and those that cannot be improved will be dealt with by "clearance areas", "closing orders" or "demolition". There were 94 new houses built in 1969, 42 by the council and 52 by private builders.

In the Border Rural District during 1969, 91 houses were completed, 80 were approved and 75 were under construction. Alterations and improvements to existing houses totalled 114 and 160 schemes were approved. The number of visits and inspections carried out by the Building Inspector during the year was 1,218.

At the end of the year there were 1,721 houses known as "Council" houses in the Wigton Rural District. Only 174 of these are owned by the Council the balance of 1,547 being owned by the North Eastern Housing Association Ltd. built at the instigation of the Council to meet the housing needs of the area.

Alston Rural District have one housing scheme of 38 dwellings under way of which 23 were completed during 1969. It is hoped the remainder will be completed by the Spring of 1970. Four privately built bungalows were built during 1969 and two further bungalows were under construction.

28 houses were completed by Whitehaven Corporation during the year and 53 are under construction. In the private sector 46 houses were completed and 20 are under construction. The great reduction in the building of council houses was planned to prevent overbuilding. This follows from the elimination of slum property and the annual available re-lettings from a large stock of local authority owned dwellings. In the Ennerdale Rural District 196 council houses were let during 1969. The confirmation in September of the Frizington Compulsory Purchase Orders meant, that, with few exceptions, the worst of the unfit houses in the area are dealt with .

Water Supplies

Of the 10 schemes submitted for observation 8 were small schemes consisting of extensions to existing mains to afford new or improved supplies. The other two schemes were submitted by the Eden Water Board one estimated to cost £64,800 and the second £22,000. Details of the schemes are set out in the following schedule.

In the Penrith Rural District the water supplies are generally satisfactory in quantity and quality, apart from poor quality on

the east fellside villages. It is expected that alternative supplies will be available to these villages in March, 1970.

Water is supplied to Penrith Urban District by the Eden Water Board and each sample of water was classified as excellent.

The Eden Water Board also supplies water to Alston Rural District. The supplies at Alston and Garrigill easily fulfill the needs both in quantity and quality but there are shortages from time to time at Nenthead. All the water in the area is untreated.

The entire water supply for Whitehaven Borough is under the control of the South Cumberland Water Board. The water is upland surface water, is naturally soft and shows no evidence of plumbo-solvency.

In the Ennerdale Rural District work is progressing on the Lake augmentation scheme phase 1 for increasing the abstraction to 14 million gallons per day and should be in operation by the middle of 1970. Further plans are in the design stage for further abstraction to ensure supplies in anticipation of industrial and domestic expansion.

Millom Rural District has maintained good liaison with the South Cumberland Water Board and of the 124 samples taken away only one was found to be unsatisfactory.

Grants

The Eden Water Board received lump sum grants on 10 small mains extension schemes, and half yearly payments for 30 years on their two large schemes, i e. Penrith Central Area scheme (Phase 2) and the Wadygill Scheme.

The Carlisle County Borough, who are responsible for the water supplies in the Border area, received grants on 3 parts of their North and Eastern Area Major Water Scheme.

In all cases the County Council made equivalent grants.

Sewerage Schemes

Only 3 schemes were submitted for observations, 2 being new schemes and the third an amended scheme to serve the proposed motor-way service area at Southwaite. The new schemes were both submitted by the Border Rural District Council and provide for sewerage and sewage disposal for the villages at Harker and Cumwhitton. Details are set out on the following schedule.

In the Penrith Rural District a new sewage disposal works for the villages of Kirkoswald and Lazonby came into operation in 1969. Work still continues on the Skirwith sewage scheme which is expected to be completed together with the Melberby scheme early in 1970.

Of the houses in Penrith Urban District 95% are connected to the public sewers the remaining 5% are connected to private septic tanks. As was pointed out in last years Report the sewage works were last improved and extended in the mid 1930's and are now working at maximum capacity. Any major development in Penrith will necessitate modernisation of the plant.

In the Border Rural District Sewerage and Sewage Disposal Schemes were completed at Heads Nook and Brampton during the year. There are several other schemes under consideration.

During the year a tender amounting to £6,551 was accepted in respect of improvements and repairs to the village sewage disposal works at Fletchertown in the Wigton Rural District. The work was completed during the year and Ministry approval was granted for extensions to the Aspatria Sewage disposal works.

The Alston Rural District's consulting engineers have prepared a scheme for enlarging the present disposal works at Alston and also for the provision and extension of sewers in two other areas of the District. Outline planning consent has been obtained, and the scheme is now ready for submission to the Ministry.

The Whitehaven Borough is fully sewered except for parts of the village of Sandwith where a small disposal unit was installed this year, and the entire sewage is discharged untreated into the sea on an unattractive part of the coast which is heavily polluted and fortunately little frequented.

In the Ennerdale Rural District 6 new drying beds were completed and put into use at the Moresby Sewage works. These replaced 4 drying beds that had insufficient drainage.

Grants

The Ministry approved 3 schemes for grants during the year as follows:—

Border Rural District Council — Heads Nook Scheme.
Penrith Rural District Council — Melmerby Scheme
Cockermouth Rural District Council — Seatoller Scheme.
The County Council made equivalent grants in all cases.

Caravan Sites

There are 23 residential caravans and 434 caravans on licensed sites in the Penrith Rural District, two of which are licensed under the Public Health Act for tented sites with a total of 80 pitches. All these sites have a high standard of amenity.

Penrith Urban District has two licensed caravan sites in its area. One, on the banks of the River Eamont, has 13 residential caravans but no tourist pitches. The other has 20 residential caravans and space for 25 touring caravans with good sanitary and washing facilities.

At the end of the year there were 1,729 caravans and chalets on licensed sites in the Wigton Rural District. There is the recurring problem of the unauthorised stationing of caravans on the sea banks along the coastline between Allonby and Silloth, which is extremely difficult to control.

Alston Rural District has two licensed caravan sites, each accommodating 12 caravans, which operate between April and October and are intended mainly for touring caravans.

At the moment there are 35 licensed caravan sites in Ennerdale Rural District, the majority of which are only licensed for single caravans and are used mainly for holiday purposes during the season.

In the Millom Rural District there are 16 licensed caravan sites capable of accommodating 245 caravans.

Water Schemes

Scheme submitted by	Name of Scheme	General Outline	Estimated or final cost	Remarks
Eden Water Board	Nord Vue Water Scheme	To develop a borehole at Nord Vue and to construct a pumping station and service reservoirs, and to lay mains to supply the proposed motorway service area at Southwaite and to augment supplies within that locality.	£64,800 (Estimated that £25,200 would be payable by the Ministry of Transport.)	Scheme approved as sound and adequate
	Wadygill Water Scheme	To improve the supply in Newbiggin, Croglin and Renwick Areas.	£22,000	Scheme approved as sound and adequate.
	Water Main at Melmerby	To lay a 2″ watermain at Melmerby	£1,180	Scheme approved as sound and adequate.
	Water main at Brick House—Inglewood Edge.	To lay a 2″ water main at Brick House—Inglewood Edge.	£1,090	Scheme approved as sound and adequate.
	Knotts—Watermillock Mains Extension. Stage 2.	To lay a 3″ diameter main from Leaming House via Watermillock to High House to serve 20 properties.	£4,160	Scheme approved as sound and adequate.
	3″ Main—Dacre to Waterfoot	A new 3″ Main to serve 12 people at present supplied by a private 2″ main.	£3,300	Scheme approved as sound and adequate.
	4″ Main—Catterlen	To lay 950 yds. of 4″ main to improve the supply in Catterlen area.	£4,590	Scheme approved as sound and adequate.
	Main at Blencarn	To lay a 2″ mains extension at Blencarn	£318	Scheme approved as sound and adequate.
West Cumberland Water Board	Main at Embleton	To lay a 3″ main extension at Embleton	£925	Scheme approved as sound and adequate.
	Main at Yearngill	To lay a 3″ main extension at Yearngill.	£740	Scheme approved as sound and adequate.

Sewerage Schemes

Scheme submitted by	Name of Scheme	General Outline	Estimated or final cost	Remarks
Border Rural District Council	Harker Sewerage and Sewage Disposal Scheme	Sewerage and sewage disposal from the village of Harker.	£26,285	In general the proposal will prove a marked improvement over present conditions but the consultants were asked to consider the possibility of producing a better standard of effluent for discharge into Blackford Beck.
	Cumwhitton Sewerage and Sewage Disposal Scheme	To provide sewerage and sewage disposal for the village of Cumwhitton.	£27,682	Scheme approved as sound and adequate.
Penrith Rural District Council	Southwaite Sewerage and Sewage Disposal Scheme	A revised scheme to include Broadfield as well as the village and proposed Motorway Service Area.	£90,000	Scheme approved as sound and adequate.

HOUSING RETURNS FOR THE COUNTY OF CUMBERLAND

For year ended 31st December, 1968

(N.B.—Corresponding figures for 1967 are shown in brackets)

		Alston R.D.C.	Border R.D.C.	Cocker-mouth R.D.C.	Ennerdale R.D.C.	Millom R.D.C.	Penrith R.D.C.	Wigton R.D.C.	White-haven Boro'	Working-ton Boro'	Cocker-mouth U.D.C.	Keswick U.D.C.	Maryport U.D.C.	Penrith U.D.C.	County Total
	Population — 1951	2,327	29,845	20,455	29,676	13,428	11,723	23,746	24,620	28,891	5,235	4,868	12,234	10,492	217,540
	(Census) — 1961	2,105	29,644	20,966	30,859	15,094	11,638	21,866	27,566	29,552	5,827	4,765	12,393	10,927	223,202
A 1	Total number of occupied dwelling houses in the district:	864 (832)	9,354 (9,243)	7,178 (7,124)	10,350 (10,194)	4,730 (4,564)	3,746 (3,715)	7,660 (7,523)	8,246 (8,167)	9,554 (9,480)	2,362 (2,339)	1,600 (1,594)	4,183 (4,173)	3,714 (3,666)	73,541 (72,614)
2	Total number of occupied dwelling houses subject to Demolition Orders. Closing Orders or Undertakings:	1 (1)	— (—)	7 (5)	26 (46)	38 (41)	22 (20)	15 (26)	12 (30)	23 (6)	11 (7)	4 (3)	52 (52)	13 (16)	224 (253)
3	Estimated number of houses (exclusive of above) which are unfit for habitation and cannot be made fit at a reasonable cost: ...	13 (13)	258 (276)	68 (109)	214 (263)	228 (229)	60 (70)	276 (258)	30 (25)	1,200† (1,500†)	106 (100)	3 (—)	55 (54)	85 (90)	2,596 (2,997)
4	Estimated number of sub-standard houses (exclusive of above) which could be repaired and made fit:	40 (45)	470 (480)	NA (NA)	NK (NK)	200 (200)	380 (390)	983 (1,030)	— (NK)	2,500§ (2,500§)	17 (17)	20 (50)	56 (52)	30 (150)	4,696 (4,914)
5	Number of houses found to be overcrowded:	5 (4)	10 (12)	3 (2)	— (—)	8 (3)	2 (7)	1 (1)	— (—)	2 (—)	— (—)	NK (—)	— (—)	8 (5)	39 (34)
B	WAITING LISTS Total number of valid applicants on Council's waiting list exclusive of those living in houses under A 2 and 3 above:	57 (56)	200 (206)	503 (507)	196 (285)	216 (161)	94* (88*)	482 (488)	571 (578)	751 (669)	230 (215)	101 (89)	388 (359)	261 (288)	4,050 (3,989)
C	NEW DWELLINGS COMPLETED DURING THE YEAR 1 By or for the Council— For aged persons	— (—)	12 (9)	— (10)	17 (40)	— (13)	10 (12)	70 (20)	— (—)	— (9)	— (—)	— (—)	— (—)	— (—)	109 (113)
	For aged persons grouped with welfare facilities	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (10)	— (—)	— (—)	— (—)	— (—)	20 (—)	— (—)	20 (10)
	For agricultural workers	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
	General purpose dwellings	4 (—)	22 (8)	— (—)	226 (206)	— (—)	4 (—)	43 (4)	24 (66)	33 (34)	— (48)	— (—)	7 (—)	— (3)	363 (369)
2	Private building:	11 (1)	95 (92)	49 (47)	43 (55)	13 (23)	19 (22)	46 (21)	46 (40)	21 (48)	48 (29)	8 (7)	10 (23)	33 (13)	442 (421)
	Total of 1 and 2 ...	15 (1)	129 (109)	49 (57)	286 (301)	13 (36)	33 (34)	159 (55)	70 (106)	54 (91)	48 (77)	8 (7)	37 (23)	33 (16)	934 (913)
D 1	Number of houses for which application was made by private persons for Grants. (Improvement and Standard Grants): ...	8 (10)	60 (50)	67 (53)	58 (58)	32 (43)	47 (52)	48 (146)	95 (25)	57 (80)	7 (15)	10 (14)	47 (44)	14 (20)	550 (610)
2	Number of houses for which grants were approved:	7 (10)	55 (42)	67 (50)	63 (87)	31 (39)	46 (55)	47 (39)	95 (24)	59 (86)	7 (15)	10 (14)	47 (44)	13 (19)	547 (524)
3	Number of houses where improvements were carried out and grants paid;	13 (7)	35 (54)	60 (71)	56 (54)	33 (34)	49 (33)	34 (52)	22 (17)	38 (56)	10 (8)	16 (10)	25 (33)	13 (11)	404 (440)
4	Number of houses purchased or taken over by the Council with a view to improvement or conversion:	— (—)	— (8)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	27 (—)	1 (—)	— (—)	1 (—)	— (—)	29 (8)
5	Number of houses improved by the Council— (i) with grant	— (—)	1 (65)	24 (8)	— (2)	— (1)	— (—)	— (1)	— (—)	22 (17)	— (—)	— (—)	— (—)	6 (2)	53 (96)
	(ii) without grant	— (—)	4 (8)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (3)	— (—)	— (—)	1 (—)	— (—)	5 (11)
E	HOUSING PROGRAMME FOR ENSUING YEAR— 1 Dwellings to be built by or for the Council— For aged persons	— (—)	10 (12)	6 (—)	— (17)	7 (4)	24 (25)	40 (76)	6 (—)	— (100)	— (—)	— (—)	12 (10)	5 (10)	110 (254)
	For aged persons grouped with welfare facilities	— (—)	— (—)	— (—)	22 (—)	10 (10)	14 (14)	— (—)	— (—)	24 (—)	— (—)	— (—)	— (22)	20 (21)	90 (67)
	For agricultural workers	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
	General purpose dwellings	30 (38)	80 (22)	18 (—)	2 (228)	21 (8)	6 (10)	4 (47)	26 (26)	40 (63)	— (—)	55 (55)	10 (30)	30 (40)	322 (567)
2	Private building	10 (12)	90 (NK)	50 (53)	45 (50)	14 (20)	25 (30)	75 (35)	40 (45)	75 (100)	35 (30)	6 (10)	30 (12)	93 (30)	588 (427)
	Total of 1 and 2 ..	40 (50)	180 (34)	74 (53)	69 (295)	52 (42)	69 (79)	119 (158)	72 (71)	139 (263)	35 (30)	61 (65)	52 (74)	148 (101)	1,110 (1,315)

* Old People only.

† Should be dealt with by demolition within a 15 year period.

§ Qualify for grant aid within a 10 year period.

HOUSING RETURNS FOR THE COUNTY OF CUMBERLAND

For year ended 31st December, 1969

(N.B.—Corresponding figures for 1968 are shown in brackets)

			Alston R.D.C.	Border R.D.C.	Cocker-mouth R.D.C.	Ennerdale R.D.C.	Millom R.D.C.	Penrith R.D.C.	Wigton R.D.C.	White-haven Boro'	Working-ton Boro'	Cocker-mouth U.D.C.	Keswick U.D.C.	Maryport U.D.C.	Penrith U.D.C.	County Total
		Population — 1951	2,327	29,845	20,455	29,676	13,428	11,723	23,746	24,620	28,891	5,235	4,868	12,234	10,492	217,540
		(Census) — 1961	2,105	29,644	20,966	30,859	15,094	11,638	21,866	27,566	29,552	5,827	4,765	12,393	10,927	223,202
A	1	Total number of occupied dwelling houses in the district:	889 (864)	9,513 (9,354)	7,235 (7,178)	10,312 (10,350)	4,582 (4,730)	3,763 (3,746)	7,700 (7,660)	8,246 (8,246)	9,595 (9,554)	2,141 (2,362)	1,668 (1,600)	4,189 (4,183)	3,680 (3,714)	74,513 (73,541)
	2	Total number of occupied dwelling houses subject to Demolition Orders, Closing Orders or Undertakings:	— (1)	— (—)	53 (7)	107 (26)	46 (38)	27 (22)	12 (15)	14 (12)	2 (23)	12 (11)	4 (4)	42 (52)	10 (13)	329 (224)
	3	Estimated number of houses (exclusive of above) which are unfit for habitation and cannot be made fit at a reasonable cost: ...	13 (13)	238 (258)	49 (68)	60 (214)	316 (228)	450 (60)	303 (276)	20 (30)	1,100 (1,200†)	117 (106)	4 (3)	55 (55)	62 (85)	2,787 (2 596)
	4	Estimated number of sub-standard houses (exclusive of above) which could be repaired and made fit:	36 (40)	450 (470)	NA (NA)	NK (NK)	216 (200)	400 (380)	946 (983)	10 (—)	2,500 (2,500§)	72 (17)	15 (20)	48 (56)	56 (30)	4,749 (4,696)
	5	Number of houses found to be overcrowded:	4 (5)	8 (10)	4 (3)	— (—)	5 (8)	3 (2)	3 (1)	— (—)	— (2)	— (—)	NK (NK)	— (—)	4 (8)	31 (39)
B		WAITING LISTS Total number of valid applicants on Council's waiting list exclusive of those living in houses under A 2 and 3 above:	60 (57)	113 (200)	558 (503)	199 (196)	170 (216)	88 (94*)	537 (482)	649 (571)	889 (751)	205 (230)	87 (101)	330 (388)	298 (261)	4 183 (4,050)
C		NEW DWELLINGS COMPLETED DURING THE YEAR														
	1	By or for the Council—														
		For aged persons	— (—)	10 (12)	6 (—)	— (17)	7 (—)	— (10)	24 (70)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	47 (109)
		For aged persons grouped with welfare facilities	— (—)	— (—)	— (—)	— (—)	10 (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (20)	— (—)	10 (20)
		For agricultural workers	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
		General purpose dwellings	23 (4)	76 (22)	22 (—)	2 (226)	20 (—)	— (4)	4 (43)	8 (24)	— (33)	— (—)	31 (—)	— (7)	42 (—)	228 (363)
	2	Private building:	3 (11)	91 (95)	35 (49)	54 (43)	15 (13)	23 (19)	51 (46)	46 (46)	27 (21)	42 (48)	5 (8)	14 (10)	52 (33)	458 (442)
		Total of 1 and 2 ...	26 (15)	177 (129)	63 (49)	56 (286)	52 (13)	23 (33)	79 (159)	54 (70)	27 (54)	42 (48)	36 (8)	14 (37)	94 (33)	743 (934)
D	1	Number of houses for which application was made by private persons for Grants. (Improvement and Standard Grants): ...	14 (8)	44 (60)	70 (67)	71 (58)	32 (32)	61 (47)	120 (48)	38 (95)	60 (57)	10 (7)	10 (10)	96 (47)	28 (14)	654 (550)
	2	Number of houses for which grants were approved:	14 (7)	39 (55)	70 (67)	66 (63)	31 (31)	53 (46)	104 (47)	38 (95)	49 (59)	10 (7)	10 (10)	96 (47)	28 (13)	608 (547)
	3	Number of houses where improvements were carried out and grants paid;	10 (13)	37 (35)	66 (60)	59 (56)	31 (33)	61 (49)	39 (34)	62 (22)	47 (38)	7 (10)	7 (16)	37 (25)	13 (13)	476 (404)
	4	Number of houses purchased or taken over by the Council with a view to improvement or conversion:	— (—)	4 (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	149 (27)	— (1)	— (—)	— (1)	1 (—)	154 (29)
	5	Number of houses improved by the Council—														
		(i) with grant	— (—)	— (1)	14 (24)	2 (—)	— (—)	— (—)	1 (—)	— (—)	9 (22)	— (—)	— (—)	— (—)	16 (6)	42 (53)
		(ii) without grant	— (—)	— (4)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (1)	— (—)	— (5)
E		HOUSING PROGRAMME FOR ENSUING YEAR—														
	1	Dwellings to be built by or for the Council—														
		For aged persons	— (—)	33 (10)	12 (6)	— (—)	8 (7)	28 (24)	21 (40)	16 (6)	20 (—)	— (—)	— (—)	4 (12)	— (5)	142 (110)
		For aged persons grouped with welfare facilities	6 (—)	— (—)	— (—)	22 (22)	— (10)	14 (14)	— (—)	— (—)	1 (24)	— (—)	— (—)	— (—)	20 (20)	63 (90)
		For agricultural workers	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
		General purpose dwellings	6 (30)	45 (80)	23 (18)	22 (2)	5 (21)	6 (6)	9 (4)	20 (26)	184 (40)	10 (—)	50 (55)	300 (10)	36 (30)	716 (322)
	2	Private building	4 (10)	90 (90)	40 (50)	50 (45)	23 (14)	25 (25)	60 (75)	40 (40)	50 (75)	45 (35)	14 (6)	40 (30)	100 (93)	581 (588)
		Total of 1 and 2 ...	10 (40)	168 (180)	75 (74)	72 (69)	36 (52)	73 (69)	90 (119)	76 (72)	255 (139)	55 (35)	64 (61)	344 (52)	156 (148)	1 474 (1,110)

* Old People only.
† Should be dealt with by demolition within a 15 year period.
§ Qualify for grant aid within a 10 year period.

APPENDICES

I. Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland.

II. Annual Report on Tuberculosis and Other Chest Diseases in East Cumberland.

III. County Council Clinics.

APPENDIX I

Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland by Dr. R. Hambridge

During 1969 there has been a further improvement in the situation arrived at last year so far as tuberculosis in West Cumberland is concerned. The Tuberculosis Register at the 31st December, 1969 was made up of the following numbers of cases:—

	Men	Women	Children	Total	
Respiratory T.B.	441	261	26	728	(949)
Non Respiratory T.B.	27	30	10	67	(63)
Total	468	291	36	795	(1012)

(Figures in brackets relate to comparable data for 1968)

Some 60 cases were removed from the Register deemed recovered during the year: and a further 20 cases died of various causes—5 of these from tuberculosis. The Register was augmented, however, by new cases diagnosed during the year; details of these are tabulated as follows:—

New Cases:	Men	Women	Children	Total
Requiring observation only	21	14	2	37
Requiring treatment				
(Respiratory)	15	2	—	17
(Non-Respiratory forms)	2	6	3	11
Total	38	22	5	65

Of 36 respiratory type cases requiring treatment drawn from both old and new case categories 50% (17) were infectious at diagnosis. Although the number of new cases is appreciably less than a few years ago the proportion of them diagnosed before they have reached a frankly infectious form has fallen from around 75% to 50%, confirming the tendency noted in this report last year.

Five patients died during the year of tuberculosis.

Examination of Contacts:

The tracing of familiar and household contacts of new cases has continued: in the main, only children and infants have been seen at Out-patients, adults being referred to the Static 100 mm. X-ray Units at Workington Infirmary and the West Cumberland Hospital. All children between the ages of 3 months and 15 years, not already vaccinated with B.C.G. at school, have been tuberculin tested (1/1000 O.T.) and non-reactors vaccinated. Below the age of three months, tuberculin testing has been dispensed with and B.C.G. vaccination given ab initio.

A total of 254 contacts—children over 15 and adults—are known to have passed through the Static M.M.R. Units, no cases of notifiable disease being found.

B.C.G. Vaccination:

A total of 331 infants and children, including new-borns, was vaccinated with B.C.G. (318 in 1968).

Static Mass X-Ray (100 mm) Units:

Two units have operated, each on a part-time basis, during the year. The reduction in the total amount of work done and the diagnostic usefulness of the units is again evident in the annual figures, details of which follow:—

STATIC M.M.R. UNITS — 1969

WEST CUMBERLAND HOSPITAL

	No. of Miniature films taken	Number recalled for clinical examination	Active T.B.	Inactive T.B.	Neoplasms	Sarcoid	Acquired Cardiac Conditions	Pneumoconiosis without PMF
General Public ...	1133	9	—	—	—	1	1	3
Doctors' Cases ...	1167	47	4	1	9	3	1	3
Contact Cases ...	99	3	—	1	—	—	1	—
Outpatients ...	790	—	—	—	—	—	—	—
Firms ...	801	2	—	—	—	—	—	—
Scholars ...	74	1	—	—	—	—	—	—
TOTALS ...	4064	62	4	2	9	4	3	6

WORKINGTON INFIRMARY

General Public ...	635	9	—	1	1	—	—	—
Doctors' Cases ...	1156	48	4	4	10	—	—	1
Contact Cases ...	155	—	—	—	—	—	—	—
Outpatients ...	3	—	—	—	—	—	—	—
Firms ...	695	3	—	—	—	—	—	—
Scholars ...	28	—	—	—	—	—	—	—
TOTALS ...	2672	60	4	5	11	—	—	1
TOTAL BOTH UNITS	6736	122	8	7	20	4	3	7
TOTAL 1968 ...	6683		5	10	11	2	4	5
TOTAL 1967 ...	8054	—	12	21	17	1	8	14

The proportion of general practitioner referrals has remained constant, representing some 35% of the total number of persons examined (36% in 1968).

Outpatient Clinics:

Sessions have continued at both Workington Infirmary and the West Cumberland Hospital at which 285 and 299 new patients were seen respectively. At each centre 652 and 660 old patients attended, giving a total of outpatient attendances for 1969 of 1896.

Inpatients:

During the year there were 63 tuberculous admissions to Homewood (46 men and 16 women); and 112 admissions of a variety of non-tuberculous conditions (87 men, 25 women), giving a total of 175 admissions. 26 patients were transferred to Seaham Hall for thoracic surgery.

Pulmonary Neoplasm:

The number of these cases diagnosed by Mass X-ray (20) was roughly double that of 1968 (11). In all, 48 cases were dealt with during the year (34 in 1968), 43 men and 5 women. The survival rate remains depressingly low, 23 of the 45 not surviving the year. Resection proved possible in 10 patients (4 in 1968). There were 8 further deaths from this cause in patients diagnosed prior to 1969.

An increasing number of sufferers from a variety of conditions giving rise to pulmonary heart disease and respiratory insufficiency are attending Chest Outpatients, and being admitted to the Chest Wards. These now outnumber the annual combined incidence of pneumoconisis and tuberculosis in West Cumberland.

APPENDIX II

Annual Report on Tuberculosis and other chest diseases in East Cumberland in 1969 by Dr. R. J. C. Southern

Introduction

1969 has seen some notable changes at the chest centre. With the retirement of Dr. Morton in August the medical staff has been reduced by 33⅓%. During the year reductions of 33⅓% have been made in nursing staff and of 25% in clerical staff.

As the number of new patients referred to the chest centre has shown a reduction of only 162 over 1968, some streamlining of the work has been necessary to prevent the service being completely overwhelmed. Many cases of chronic non-tuberculous respiratory disease are no longer being seen at the chest centre routinely, but only at the request of their doctors, and the unrewarding long-term follow-up of contacts of successfully treated cases of tuberculosis has also been curtailed. It remains to be seen whether these measures are sufficient or whether some curtailment of the present service will be unavoidable.

The new X-ray Department at the City General Hospital was opened in the latter part of the year. Although much less convenient for our patients, who now have to go outside to the new building for their x-rays, a more rapid and efficient service is provided.

A total of 9,637 attendances was recorded at the chest centre during the year, of these 1,437 were new cases; this compares with 1,772 new cases seen at the medical out-patient clinics.

Tuberculosis

Table 1 shows the number of cases on the Tuberculosis Register at 31.12.69.

Table 1

	East Cumberland	Carlisle City	North Westmorland	Total
Non-Respiratory	18	21	2	41
Respiratory	130	145	16	291
	148	166	18	332 (371)

63 cases were removed from the Register during the year, of which 29 died of various causes.

Table 2 shows the number of new cases diagnosed during the year, the figures being almost unchanged.

Table 2

	Respiratory				Non-Respiratory			
	M	W	Ch	Totals	M	W	Ch	Totals
East Cumberland	4	4	0	8 (6)	2	0	0	2 (3)
Carlisle City	7	2	0	9 (12)	0	2	1	3 (3)
North Westmorland	1	0	0	1 (1)	0	0	0	0 (0)
	12	6	0	18 (19)	2	2	1	5 (6)

The 11 remaining beds at Blencathra Hospital were given up during the year, all patients now being treated either in Ward 18 at the Cumberland Infirmary or at Longtown Hospital.

Table 3

Hospital	Beds available	No discharged in 1969	No. discharged in 1968
Ward 18 C.I.C.	13	247	239
Longtown Hospital ...	26	115	134
Blencathra Hospital ...	— (since Sept. 1969)	24	29

Two effective new drugs—Rifampicin and Thambutol—have become available during 1969 and these have proved valuable in treatment of the few drug resistant patients. Any but the most advanced case of tuberculosis can now be almost guaranteed a cure if the correct treatment is given. But the old problems remain —the patient who stops taking his drugs after discharge from hospital, the vagrant who decamps in the middle of his treatment, and the contact who refuses to attend for examination.

A disquieting fact is that of the 18 new cases of respiratory tuberculosis notified in 1969, 14, or 77%, had a positive sputum test; five years ago it was about 30%. A number of these patients had extensive disease and must have been infectious for months before diagnosis. One wonders whether the absence of mobile mass radiography during the last two years has any bearing on the failure to diagnose cases in the early stages.

Examination of Contacts

Examination of contacts has continued as before. We depend upon the Local Authority nurses to supply the names and addresses of those who should be examined. All contacts under the age of 21 are Mantoux tested and negative reactors are vaccinated with B.C.G. vaccine.

A total of 1,296 new contacts were seen compared to 1,112 for 1968. One case of notifiable disease resulted from these examinations.

Table 4 shows the number of B.C.G. vaccinations carried out during the year:—

Table 4

	Male	Female	Total
Carlisle City	45	40	85
East Cumberland ...	28	32	60
North Westmorland ...	2	9	11
Hospital staffs ...	6	55	61
	81*	136	217(312)

The routine examination of all Mantoux positive school children has been continued. No case of active disease has been found amongst these children during the year.

Bronchial carcinoma

Table 5 shows the number of new cases of bronchial carcinoma seen during the year; the figures show an increase of one case.

Table 5

East Cumberland	Males	Females	Total
New cases ...	21	4	25 (26)
Submitted for surgery	6	—	6 (0)
Carlisle City			
New cases ...	16	8	24 (29)
Submitted for surgery	—	—	— (2)
North Westmorland			
New cases ...	8	1	9 (2)
Submitted for surgery	—	—	— (—)

17 were discovered by Mass Radiography. The outlook remains extremely depressing and 23 of the 58 cases diagnosed had died before the end of the year. There have been no new developments in treatment and prevention remains of prime importance. It is surprising how many of these patients are able to give up smoking cigarettes after the diagnosis has been made and sad that so few smokers are able to stop before they become ill.

Some of these patients have received palliative radiotherapy at Carlisle and others at Newcastle.

Asthma

Asthma is becoming more prevalent and several interesting discoveries have been made in the past few years. The importance of allergy to the house dust mite as a cause of asthma has been established, and also the place of the mould Aspergillus Fumigatus in the production of transient x-ray shadows. The risk of sudden death from over-dosage of pocket inhalers is now accepted. Finally the place of the new drug—Di sodium cromoglycate (Intal), which is dramatically successful in some cases of asthma is becoming clearer.

An attempt is being made to put the treatment of asthma on a more scientific basis through the use of sensitivity tests and tests of lung function.

Mass Radiography.

The Static unit at 1 Brunswick Street has continued to operate throughout the year and there has been an increase in the number of films taken. Table 6 is a summary of the work done.

Table 6

Carlisle Static Unit

	1969	1968
Miniature films	6419	6259
Referred for clinical examination ...	324	360
Active tuberculosis	4	3
Inactive tuberculosis	14	25
Bronchiectasis	5	7
Neoplasm	17	15
Pneumoconiosis	1	1
Sarcoidosis	2	1
Cardiac Conditions	29	36
Doctors' cases	3152	2966
Contacts per chest centre	37	251
General public	2416	2368
Works personnel	814	667

The value of a Mass Radiography unit tends to be judged by the number of cases of active tuberculosis discovered, and four such cases may not seem an impressive total, but many other significant abnormalities are brought to light through Mass Radiography, not all of which are specified in the table. Negative reports may also, of course, be most valuable.

Considerable use is made of the Unit by the local authorities for examination of new staff on appointment and for the periodic check of those in contact with children.

Acknowledgements

My thanks are due to Dr. H. L. R. Sargant and to the nursing and clerical staff for their hard work and co-operation during the past year.

APPENDIX III

County Council Clinics

Centre	Address	Clinic Services
Alston ...	Cottage Hospital, Alston	Child Welfare, Chiropody, Dental, Family Planning, Vaccination and Immunisation.
Aspatria ...	St. Mungo's Park, Aspatria	Child Welfare, Dental, Social Classes for Blind and other handicapped, Speech Therapy, Vaccination and Immunisation.
Brampton ...	Union Lane, ... Brampton	Cervical Cytology, Child Welfare, Child Care (Children's Department) Chiropody, Dental, Speech Therapy Vaccination and Immunisation.
Broughton ...	Nurse's House, ... Little Broughton	Child Welfare.
Carlisle ...	14 Portland Sq., ... Carlisle	Artificial Limbs and appliance, Cervical Cytology, Child Guidance, Chiropody, Dental, Hearing Therapy, Ophthalmic, Orthoptic, Orthopaedic, Speech Therapy.
Cleator Moor ...	Ennerdale Rd, ... Cleator Moor	Ante-Natal, Cervical Cytology, Chiropody, Dental, Vaccination and Immunisation.
Cockermouth ...	Harford House, ... Cockermouth	Cervical Cytology, Child Welfare, Chiropody, Dental, Ophthalmic, Relaxation, Speech Therapy, Vaccination and Immunisation.
Dalston ...	Victory Hall, ... Dalston	Child Welfare.
Dearham ...	Nurse's House, ... Central Road, Dearham.	Child Welfare.
Egremont ...	St. Bridget's ... Lane, Egremont	Ante-Natal, Child Welfare, Chiropody, Speech Therapy, Vaccination and Immunisation.

Centre	Address	Clinic Services
Frizington ...	Council Chambers, Frizington ...	Ante-Natal, Vaccination and Immunisation.
Houghton ...	The Village Hall, Houghton ...	Child Welfare, Vaccination and Immunisation.
Hunsonby ...	The Village Institute, Hunsonby ...	Child Welfare, Vaccination and Immunisation.
Keswick ...	13-15 Bank St., Keswick ...	Cervical Cytology, Child Welfare, Dental, Ophthalmic, Relaxation, Speech Therapy, Vaccination and Immunisation.
Longtown ...	Burn Street, Longtown ...	Cervical Cytology, Child Welfare, Dental, Mothercraft, Orthopaedic, Playgroup, School Clinic, Vaccination and Immunisation.
Maryport ...	24 Selby Terrace, Maryport	Ante-Natal, Cervical Cytology, (at Surgery), Child Guidance, Child Welfare, Chiropody, Dental, Obesity, Speech Therapy, Vaccination and Immunisation.
Millom ...	18, St. George's... Road, Millom	Ante-Natal, Cervical Cytology, Child Guidance, Child Welfare, Dental, Family Planning, Speech Therapy, Vaccination and Immunisation.
Nenthead ...	Overwater ... Nenthead	Child Welfare.
Penrith ...	Brunswick ... Square, Penrith	Cervical Cytology, Child Care, (Children's Dept.), Child Welfare, Chiropody, Dental, Family Planning, Hearing Therapy, Marriage Guidance, Mothercraft, Orthopaedic, Orthoptic, Probation, Psychiatric, Speech Therapy, Vaccination and Immunisation.
Scotby ...	The Village Hall, Scotby	Child Welfare, Vaccination and Immunisation.

Centre	Address	Clinic Services
Seascale ...	Gosforth Road, Seascale	Child Welfare, Dental, Chiropody, Vaccination and Immunisation.
Seaton ...	Miners' Welfare Hall, Seaton	Child Welfare, Vaccination and Immunisation.
Thornhill ...	Community Centre, Thornhill.	Child Welfare.
Thursby ...	The Church Hall, Thursby	Child Welfare.
Wetheral ...	The Village Hall, Wetheral	Child Welfare, Vaccination and Immunisation.
Whitehaven ...	Flatt Walks, Clinic, Whitehaven	Ante-Natal, Cervical Cytology, Child Guidance, Child Welfare, Chiropody, Dental, Family Planning, Hearing Therapy, School Speech Therapy, Vaccination and Immunisation.
Mirehouse ...	Dent Road, Mirehouse, Whitehaven	Ante-Natal, Child Welfare, Vaccination and Immunisation.
Woodhouse	Woodhouse, Whitehaven	Child Welfare, Mothercraft, Vaccination and Immunisation.
Wigton ...	Birdcage Walk, Wigton	Ante-Natal, Cervical Cytology, Child Welfare, Chiropody, Dental, Orthopaedic, Speech Therapy, Vaccination and Immunisation.
Workington ...	Park Lane, Workington	Cervical Cytology, Child Guidance, Child Welfare, Chiropody, Dental, Family Planning, Hearing Therapy, Marriage Guidance, School Speech Therapy.
Salterbeck ...	Holden Road, Salterbeck, Workington	Cervical Cytology, Child Welfare, Chiropody, Dental, Vaccination and Immunisation.

Printed by
BORDER PUBLICITY CO. LTD.,
Atlas Works, Nelson Street,
CARLISLE